IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JIAN REN HE, individually and on behalf of the classes defined below,	)	
Plaintiff,	)	
vs.	)	1:19-cv-03300 Judge Lefkow
MIDWEST ORTHOPAEDICS AT RUSH, LLC,	)	
Defendant.	)	

AMENDED COMPLAINT – CLASS ACTION

INTRODUCTION

1. Plaintiff Jian Ren He brings this action to secure redress from improper billing and collection practices engaged in by Midwest Orthopaedics at Rush, LLC ("MOR").

JURISDICTION AND VENUE

2. This matter was removed by Defendant on May 16, 2019. Two of Plaintiff's claims arise under the Employee Retirement Income Security Act ("ERISA"). The validity of a purported waiver of benefits that MOR had Plaintiff sign (Appendix E) is governed by federal common law insofar as MOR applied it to ERISA plan benefits. All other claims are within the Court's supplemental jurisdiction.

3. Venue in this district is proper because the action was removed from the Circuit Court of Cook County.

PARTIES

4. Plaintiff is an individual who resides in Cook County, Illinois. Plaintiff speaks and reads Chinese but not English.

5. Defendant MOR is an Illinois limited liability company with offices at 1611 W. Harrison St., Suite 300, Chicago, IL 60612. Its registered agent and office is CT Corporation System, 208 S. LaSalle St., Suite 814, Chicago, IL 60604.

6. Defendant MOR employs numerous physicians and therapists at more than 20 locations and has annual revenue exceeding $20 million.

FACTS

7. In 2017-2018, Plaintiff was a beneficiary of the Amalgamated National Health Fund health plan, as a result of his wife's employment as a garment worker.

8. The Amalgamated National Health Fund health plan is an "employee welfare benefit plan" as defined in §3(1) of ERISA, 29 U.S.C. §1002(1). The Amalgamated National Health Fund was formed through the merger of many funds affiliated with the former Amalgamated Clothing and Textile Workers Union, the International Ladies Garment Workers Union, UNITE Here, Workers United, SEIU and other funds. It is a large, multi-employer ERISA Taft-Hartley Health & Welfare Fund with over 500 contributing employers nationwide representing diverse industries, including manufacturing, distribution, food service, laundry, dry cleaning, retail, textiles, and others.

9. Plaintiff is a beneficiary of the Amalgamated National Health Fund health plan pursuant to a collective bargaining agreement (Appendix A) between the employer of plaintiff's wife and an SEIU affiliate.

10. The Amalgamated National Health Fund directly or indirectly contracted with Blue Cross and Blue Shield of Illinois ("BCBSIL") to act as a group administrator. BCBSIL was required to carry out the terms of the plan and could not change or depart from it in any manner.

11. Because the Fund is a Taft-Hartley fund, the agreement of both employer and union (or a determination by an arbitrator, pursuant to Appendix A, Exhibit #I, paragraph 5) is required for changes.

12. The collective bargaining agreement (Appendix A, Exhibit #I, paragraph 4) does not authorize the employee or beneficiary to dispense with or receive monetary consideration in lieu of the bargained-for health benefits, stating:

> No employee shall have the option to receive instead of the benefits provided for by the Trust Agreement or Plan any part of the contribution of the Employer. No employee shall have the right to assign any benefits to which he or she may be or become entitled under the Trust Agreement or Plan, or to receive a cash consideration in lieu of such benefits either upon termination of the trust therein created or through severance of employment or otherwise.

13. A copy of the Summary Plan Description for the Amalgamated National Health Fund is attached as Appendix B.

14. Contributions were made to the Amalgamated National Health Fund health plan on behalf of plaintiff's wife on a periodic basis, regardless of whether any medical services were required in a particular period.

15. On or about September 12, 2017, Plaintiff was injured in an automobile accident caused by a third party tortfeasor. Plaintiff was a passenger in one of the two vehicles involved and not at fault.

16. On or about December 20, 2017, Plaintiff sought treatment from MOR because it was in-network with the Amalgamated National Health Fund health plan.

17. Prior to December 20, 2017, MOR entered into agreements with BCBSIL and other benefit providers ("group administrators") to provide "in network" medical services to patients enrolled in health benefit programs administered by the group administrators.

18. The group administrators agreed to compensate MOR according to the terms of the agreements and to encourage their members and beneficiaries to use MOR for medical services.

19. MOR agreed to accept discounted payments for its services.

20. The agreements also provide that MOR must make a claim to the group administrators within specified times.

21. The agreements further provide that MOR may not charge the patient anything other than a modest deductible or copay.

22. MOR has a web site on which it lists some of the benefit plans for which it is "in network". A copy is attached as Appendix C.

23. Shortly before December 20, 2017, Plaintiff's son called MOR, identified Plaintiff's plan, and was informed that MOR was in-network. Plaintiff understood that this meant that everything would be billed to the Amalgamated National Health Fund via BCBSIL. Had this not been the case, Plaintiff would not have gone to MOR.

24. When he first visited MOR on December 20, 2017, Plaintiff presented his health benefits card, which states the name of the group as "Amalgamated National Health Fund." (Appendix D) He was asked to and did pay his copay, in cash.

25. MOR was thus well aware that Plaintiff was the beneficiary of the Amalgamated National Health Fund. The name of the Fund reveals that it is a Taft-Hartley fund, which is confirmed by any inquiry as to its nature.

26. On December 20, 2017, Plaintiff saw Dr. Nikhil Verma, who scheduled surgery for Plaintiff on February 6, 2018, ordered images to be taken and prescribed a plan of treatment.

27. At the time Plaintiff was in substantial pain and distress and in urgent need of continuous and further treatment.

28. When taking a history, MOR obtained a copy of the police report relating to the accident. Plaintiff did not understand the significance of the request at the time. It was to ascertain whether Plaintiff had a likely tort recovery.

29. Under the Amalgamated National Health Fund plan, the plan is subrogated to any rights that the beneficiary had against a third party tortfeasor for the amount that the plan pays for services to the beneficiary – at the reduced rates that the medical providers agreed to accept from the Fund.

30. This was reflected in the Summary Plan Description pertaining to the Amalgamated National Health Fund (Appendix B), which provided:

> The Fund will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your, your spouse's or your eligible dependent's insurer including coverage under an automobile insurance policy which includes your or your dependant's own underinsured or uninsured coverage) to the fullest extend [sic] permitted by any law. *The amount of such subrogation will equal the total amount paid under the Fund arising out*

> *of the injury or illness for which you, your total spouse or your eligible dependent (or your, your spouse's or eligible dependent's guardian or estate) has, may have or asserts a cause of action*. In addition, the fund will be subrogated for attorney's fees incurred in enforcing its subrogation rights hereinunder. (Emphasis added)

The relevant provisions are at pp. 35-36 of Appendix B.

31. Appendix B refers to the discounted rate medical providers such as MOR agreed to accept as the "network rate." The Amalgamated National Health Fund health plan would pay in-network medical providers 80% to 100% of the "network rate," with modest copays and deductibles.

32. On information and belief, BCBSIL, on behalf of the Amalgamated National Health Fund, negotiated reduced rates with other medical providers that provided services to Plaintiff in connection with the occurrence, and paid, about 20%-30% of the face amount of the medical bills.

33. On information and belief, Amalgamated National Health Fund and its group administrator, BCBSIL, regularly entered into contracts with medical providers such as MOR that impose obligations corresponding to the above-quoted provisions – i.e., the medical provider will accept the amount paid by the group administrator and the Amalgamated National Health Fund health plan will have the sole right to any lien.

34. BCBSIL was not authorized to depart from the terms of the plan, any change in which would require agreement by the union and employer sponsors of the plan (or a decision by an arbitrator).

35. Such subrogation provisions are standard and authorized provisions in ERISA plans, and pre-empt state laws relating to subrogation rights. *FMC Corp. v. Holliday,* 498 U.S. 52 (1990); *Hampton Indus. Inc. v. Sparrow,* 981 F.2d 726, 728 (4th Cir. 1992); *Pike v. Premier Transportation & Warehousing, Inc*., 13cv8835, 2017 WL 951323, at *3 (N.D. Ill. Mar. 10, 2017) (Illinois medical lien statutes preempted); *Biomet, Inc. Health Ben. Plan v. Black*, 51 F. Supp. 2d 942, 949 (N.D. Ind. 1999).

36. The assertion of subrogation rights by the plan is necessarily inconsistent with the

assertion of lien rights by the medical providers (here, MOR) for the same services.

37. Plaintiff does not have a copy of MOR's contract with BCBSIL or the Fund's contract with BCBSIL, but on information and belief they are consistent with the Summary Plan Description, i.e., subrogation and lien rights belong to Amalgamated National Health Fund and not the medical providers.

38. On information and belief, MOR was well aware that:

a. The Amalgamated National Health Fund was an employee benefit plan;

b. Employee benefit plans generally provide that the plan may recover from third party tortfeasors.

39. On or about January 22, 2018, after Plaintiff was already being treated by MOR, and surgery had been scheduled to relieve substantial pain, MOR presented Plaintiff with the document attached as Appendix E, purporting to waive "my health insurance benefits with Blue Cross and Blue Shield of Illinois" [sic]. The document stated that "MOR is intending to seek payment from me or a third-party, which may include a recovery of funds from any settlement or award from any such third-party regardless of whether such third-party admits or denies liability for my claims."

40. Appendix E further stated that "MOR will seek its full billed charges or other appropriate amounts from me or any such third-party and will not be submitting bills at any discounted rates that were agreed upon with BCBSIL, and that BCBSIL will not have any responsibility for payments in connection with any healthcare services that are covered by or provided in connection with this waiver letter that, if it were not for the execution of this waiver letter, would have otherwise been considered to be eligible for benefits and/or payable by BCBSIL under my health benefits plan with BCBSIL."

41. MOR told Plaintiff, via his son, that in order to continue treatment Plaintiff had to sign Appendix E. Plaintiff accordingly signed it.

42. There is no consideration for the waiver of rights in Appendix E.

43. Relief from copays and deductibles is not such consideration because the patient is purportedly agreeing to pay a much larger sum for the same treatment. It is certainly not the adequate consideration necessary to validate a transaction between physician and patient.

44. Appendix E is inconsistent with public policy, under which the employee or beneficiary is entitled to receive health care pursuant to the collective bargaining agreement and benefits plan and may not negotiate other contractual arrangements with the persons who are involved with administering the plan or providing care pursuant to the plan.

45. Plaintiff was provided with and required to execute Appendix E prior to any discussions with an attorney relating to the injury-causing incident.

46. Plaintiff did not understand the nature of Appendix E and its application by MOR until the spring of 2019.

47. Appendix E is ambiguous, confusing, misleading, and unenforceable with respect to Plaintiff's ERISA benefits by its terms, in that:

a. Plaintiff did not have "health insurance benefits with Blue Cross and Blue Shield of Illinois."

b. Plaintiff was entitled to health care benefits under the Amalgamated National Health Fund plan as a result of a collective bargaining agreement between a union to which his wife belonged and his wife's employer.

c. Neither Plaintiff nor his wife had contracted with BCBSIL

d. BCBSIL had merely been hired as an administrative agent for the Amalgamated National Health Fund. BCBSIL had no authority or right to change the terms of the plan or to do anything inconsistent with the plan.

e. Appendix E represents that MOR has rights under the Illinois medical lien law. This is false, as ERISA preempts state lien laws.

f. While Appendix E states that execution is "voluntary," Plaintiff was informed that unless he "voluntarily" executed it, MOR would not

continue treatment.

48. MOR nevertheless interprets and applies Appendix E to apply to ERISA plan benefits, including Plaintiff's Amalgamated National Health Fund benefits.

49. As interpreted and applied by MOR, under Appendix E:

a. The patient surrenders his or her right to obtain ERISA benefits for which the patient (or the patient's spouse or parent) has contracted or paid, and assumes personal liability for his or her treatment that would not otherwise exist.

b. MOR obtains the right to seek more from the patient or a third party tortfeasor than it has already contracted to accept.

c. There is no benefit or other consideration to the patient whatever.

50. The only reason a patient would sign a document in the form of Appendix E is lack of understanding or overreaching.

51. The presentation of a document in the form of Appendix E with respect to ERISA benefits is contrary to the agreements between MOR and the group administrators with which MOR has contracted, here BCBSIL, and deprives plan members of their ERISA rights.

52. The presentation of a document in the form of Appendix E by a medical provider such as MOR after the inception of the physician-patient relationship and as a condition of continuing a course of treatment already undertaken is a breach of the medical provider's fiduciary duty to the patient. The medical provider is drastically increasing the amount that the patient is obligated to pay personally, for no reason other than the medical provider's gain, as a condition of not abandoning or harming the patient with respect to medical treatment.

53. Documents in the form of Appendix E are presumptively invalid if entered into after the inception of the physician-patient relationship.

54. Appendix E is a form document.

55. MOR regularly uses documents in the form represented by Appendix E when it

learns that the patient may have a tort claim.

56. MOR regularly uses documents in the form represented by Appendix E after the inception of the physician-patient relationship.

57. MOR is asserting a lien against Plaintiff's tort recovery (Appendices F-H).

58. MOR has a policy and practice, when treatment of a group member is necessitated by injuries inflicted by a third party tortfeasor, of demanding payment of undiscounted amounts from the patient's recovery even though they have agreed and are required to accept a lesser payment from the member's group administrator.

59. MOR adheres to this policy and practice with respect to benefits under ERISA plans.

60. MOR engages in this policy and practice because it believes that it will recover more by placing a lien on the patient's tort recovery under the purported authority of the Health Care Services Lien Act, 770 ILCS 23/1 et seq., or from the patient, than it is entitled under MOR's contracts with the group administrator.

61. Since insurance companies and attorneys representing tortfeasors insist that all persons who have asserted a lien be named on a check representing proceeds of a claim, MOR's policy and practice holds the patient's settlement hostage to compliance with its unlawful demands.

62. Any amounts obtained by MOR as a result of its lien will have been collected from Plaintiff because any judgment or settlement of Plaintiff's tort claim becomes his property.

63. MOR's policy and practice is contrary to the agreements between MOR and the group administrators with which MOR has contracted, here BCBSIL, and deprives plan members of their rights.

64. Under MOR's policy and practice, Plaintiff will end up paying over $6,000 more than had MOR presented a claim to Amalgamated National Health Fund via BCBSIL, the Fund paid the claim, and the Fund asserted its subrogation right under the plan.

65. In addition, MOR was paid under the medical payment provisions of (a) the auto insurance policy of the driver of the car in which Plaintiff was riding at the time of the accident and (b) Plaintiff's own auto insurance policy. Had MOR presented a claim to the Fund, the proceeds of those policies would have been used to reimburse the Fund pursuant to its subrogation rights under the plan – at the negotiated rate of 20%-30% of what MOR demanded.

66. There is a controversy between Plaintiff and the class on the one hand and MOR on the other with respect to MOR's policy and practice of imposing liens on a patient's tort recovery and using documents in the form of Appendix E.

67. A declaratory judgment will resolve the controversy between the parties.

CLASS ALLEGATIONS

68. Plaintiff brings this action on behalf of a class and subclass pursuant to Fed.R.Civ.P. 23(a), (b)(2) and (b)(3).

69. The class consists of all persons (a) from whom MOR has demanded (directly or through its agents, and whether personally or from a tort recovery) payment of an undiscounted bill, (b) which bill is subject to a contract between MOR and a group administrator, (c) where the benefits are provided pursuant to a plan provided through non-governmental employment (i.e., one subject to ERISA), (d) and the bill is currently outstanding or was paid within the class period prior to the filing of this action.

70. The class period is as follows, prior to the initial filing of this action in state court:

Count I	5 years
Count II	10 years
Count III	5 years
Count IV	5 years
Count V	3 years
Count VI	5 years
Count VII	5 years

71. The subclass consists of all class members who signed a document in the form represented by Appendix E.

72. The class and subclass are so numerous that joinder is impracticable. On information and belief, there are more than 50 members of the class.

73. There are questions of law and fact common to the members of the class, which common questions predominate over any questions that affect only individual class members.

74. The predominant common questions are whether the policy and practice described above:

a. Is based on an unwarranted construction of Appendix E to apply to benefits under an ERISA plan.

b. Is based on an unwarranted construction of Appendix E to apply to benefits under a Taft-Hartley plan;

c. Involves assertion of an invalid lien;

d. Is a breach of the group administrator's contract with MOR;

e. Constitutes tortious interference with the patient's expectation of realizing on his or her personal injury claim and the contract between the patient and counsel prosecuting the personal injury claim.

f. Violates the patient's plan, which is implemented by the group administrator's contract with MOR.

g. Constitutes a breach of fiduciary duty.

h. Is an unfair or deceptive business practice.

i. Violates ERISA.

75. Plaintiff will fairly and adequately represent the interests of the class members. Plaintiff has retained counsel experienced in consumer fraud, collection abuse and class action cases.

76. Plaintiff's claim is typical of the claims of the class members. All are based on

the same factual and legal theories.

77. A class action is a superior means for adjudicating this dispute. Individual cases are not economically feasible.

COUNT I – CONSTRUCTION AND VALIDITY OF APPENDIX E

78. Plaintiff incorporates paragraphs 1-77.

79. Appendix E does not by its terms apply to benefits under an ERISA plan.

80. Defendant MOR wrongfully applies Appendix E to benefits under an ERISA plan.

81. Appendix E is not a valid waiver of benefits under an ERISA plan, for the reasons stated above, including its deceptive nature, lack of consideration, and imposition after the inception of the physician-patient relationship.

82. Declaratory and injunctive relief are required to prevent MOR from engaging in such conduct and to restore benefits of which Plaintiff and the class were deprived of as a result.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and the subclass members and against defendant for:

i. A declaration that Appendix E has no application to benefits payable under an ERISA plan.

ii. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

iii. An injunction restraining the practice complained of;

iv. Appropriate monetary relief;

v. Costs of suit;

vi. Such other or further relief as the Court deems proper.

COUNT II – BREACH OF CONTRACT

83. Plaintiff incorporates paragraphs 1-77.

84. Defendant's policies, practices and acts constitute a breach of the contract

between the medical provider (MOR) and the group administrator (here, BCBSIL), intended to carry out the patient's benefit plan.

85. The patient (Plaintiff and class members) is an intended third party beneficiary of the group administrator-MOR contract, in that such contract implements the benefit plan under which the patient receives benefits. The patient pays a monthly amount (directly or through a relative or employer) under his or her benefit plan for the express purpose of obtaining health care with minimal additional outlay, and the group administrator-MOR contract is necessary to provide that benefit to the patient, which it does by restricting the amount which the patient can be required to pay.

86. Plaintiff has performed all conditions precedent under Plaintiff's benefit plan (which consists of paying or having paid monthly premiums).

87. Plaintiff has been damaged by Defendant's breach.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and the class members and against defendant for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are unenforceable;

iii. An injunction restraining the practice complained of;

iv. Compensatory damages;

v. Costs of suit;

vi. Such other or further relief as the Court deems proper.

COUNT III – TORTIOUS INTERFERENCE WITH CONTRACT AND ECONOMIC ADVANTAGE

88. Plaintiff incorporates paragraphs 1-77.

89. Plaintiff had a legitimate expectation of economic advantage through the prosecution of his personal injury claim and had entered into a contract with personal injury

counsel for the purpose of prosecuting that claim.

90. Class members had similar expectations with respect to their claims.

91. Defendant unlawfully interfered with the realization of such advantage by wrongfully placing a lien on the recovery, interfering with and preventing its disbursement pursuant to the settlement agreements with the tortfeasor's insurance carrier and the contract with Plaintiff's counsel. Plaintiff's personal injury counsel was required to set aside an amount sufficient to cover MOR's lien.

92. Defendant acted similarly with respect to the class members

93. Plaintiff has been damaged by defendant's conduct.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and the class members and against Defendant for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are unenforceable;

iii. An injunction restraining the practice complained of;

iv. Compensatory and punitive damages;

v. Such other or further relief as the Court deems proper.

COUNT IV – BREACH OF FIDUCIARY DUTY

94. Plaintiff incorporates paragraphs 1-77.

95. MOR's conduct in obtaining patient's signatures on documents in the form of Appendix E, subsequent to the inception of the physician-patient relationship (at the initial consultation) between MOR and the patient, is an exploitation of the physician-patient relationship and a breach of fiduciary duty.

96. Plaintiff has been damaged by MOR's conduct.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and

the class members and against MOR for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are unenforceable;

iii. An injunction restraining the practice complained of;

iv. Compensatory damages;

v. Punitive damages;

vi. Costs of suit;

vii. Such other or further relief as the Court deems proper.

COUNT V – CONSUMER FRAUD ACT

97. Plaintiff incorporates paragraphs 1-77.

98. The acts and practices described above are unfair and deceptive practices in violation of 815 ILCS 505/2.

99. Defendant's practices are deceptive and deprive the patients of their health benefits through deceit, wrongful assertion of nonexistent lien rights against third parties, and exploitation of the physician-patient relationship.

100. Defendant's practices are also unfair, in that:

a. They are contrary to public policy;

b. They violate the duty of a physician not to withhold or delay treatment for personal gain;

c. They result in the obtaining of money to which defendant is not entitled;

d. They are unscrupulous and contrary to good conscience.

101. Defendant's practices inflict thousands of dollars of injury on each patient.

102. Plaintiff has been damaged by Defendant's conduct.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and

the class members and against Defendant for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are unenforceable;

iii. An injunction restraining the practice complained of;

iv. Compensatory damages;

v. Punitive damages;

vi. Attorney's fees, litigation expenses and costs of suit;

vii. Such other or further relief as the Court deems proper.

COUNT VI – ERISA

103. Plaintiff incorporates paragraphs 1-77.

104. ERISA, 29 U.S.C. §1140, "Interference with protected rights," provides:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act, or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter or the Welfare and Pension Plans Disclosure Act. In the case of a multiemployer plan, it shall be unlawful for the plan sponsor or any other person to discriminate against any contributing employer for exercising rights under this chapter or for giving information or testifying in any inquiry or proceeding relating to this chapter before Congress. The provisions of section 1132 of this title shall be applicable in the enforcement of this section.

105. Defendant's practices represent an attempt to prevent participants and beneficiaries of ERISA plans from exercising their right to medical benefits pursuant to those plans.

106. The only purpose of requiring someone who has presented a card identifying an ERISA plan to execute a document in the form of Appendix E is to prevent the person from obtaining benefits under the plan.

107. Plaintiff has been damaged by defendant's conduct.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and the class members and against defendant for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are unenforceable;

iii. An injunction restraining the practice complained of;

iv. Appropriate monetary relief;

v. Attorney's fees, litigation expenses and costs of suit (29 U.S.C. §1132(g));

vi. Such other or further relief as the Court deems proper.

COUNT VII – ERISA

108. Plaintiff incorporates paragraphs 1-77.

109. ERISA, 29 U.S.C. §1132, authorizes civil actions "to recover benefits due to him under the terms of his plan" and "to enforce his rights under the terms of the plan . . . ."

110. In order to recover benefits due to him under the terms of the Amalgamated National Health Fund health plan and to enforce his rights under the terms of the Amalgamated National Health Fund health plan, Plaintiff and others similarly situated must invalidate Appendix E, require MOR to submit claims pursuant to the plan, and prevent MOR from billing patients for anything other than an authorized deductible or copay.

WHEREFORE, Plaintiff requests that the Court enter judgment in favor of Plaintiff and the class members and against defendant for:

i. A declaration that MOR's imposition of a lien on the tort recoveries of Plaintiff and the class members is unlawful;

ii. A declaration that documents in the form of Appendix E are

unenforceable;

iii. An injunction restraining the practice complained of;

iv. Appropriate monetary relief;

v. Attorney's fees, litigation expenses and costs of suit (29 U.S.C. §1132(g));

vi. Such other or further relief as the Court deems proper.

/s/ Daniel A. Edelman
Daniel A. Edelman

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JURY DEMAND

Plaintiff requests trial by jury with respect to all claims so triable.

/s/ Daniel A. Edelman
Daniel A. Edelman

NOTICE OF LIEN AND ASSIGNMENT

Please be advised that we claim a lien upon any recovery herein for 1/3 or such amount as a court awards. All rights relating to attorney's fees have been assigned to counsel.

/s/ Daniel A. Edelman
Daniel A. Edelman

Daniel A. Edelman
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APPENDIX A

AGREEMENT

Between

OXXFORD CLOTHES, INC.

and

CHICAGO AND MIDWEST REGIONAL JOINT BOARD,
WORKERS UNITED / AN SEIU AFFILIATE
333 SOUTH ASHLAND AVENUE
CHICAGO, IL 60607
TEL: 312-738-6100
FAX: 312-738-9985
www.cmrjb.org

Effective – October 1, 2016 to September 30, 2019

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AGREEMENT

AGREEMENT dated as of October 1, 2016 by and between OXXFORD CLOTHES, INC. (hereinafter referred to as "Employer") and the CHICAGO & MIDWEST REGIONAL JOINT BOARD, affiliated with Workers United/SEIU (hereinafter referred to as "Union").

WITNESSETH:

WHEREAS, the parties hereto desire also to establish a standard of conditions under which employees shall work for the Employer during the term of this Agreement, and desire to regular mutual relations between the parties hereto with a view of securing harmonious cooperation between them and averting disputes;

NOW, THEREFORE, in consideration of the mutual covenants herein set forth, the parties agree as follows:

ARTICLE I – RECOGNITION

Section 1. The term "employee" as used in this Agreement shall continue to be defined as heretofore.

Section 2. Exclusive Bargaining Representative: The Employer recognizes the Union as the exclusive collective bargaining agent for its employees with reference to wages, hours and working conditions.

Section 3. Union Representative: The Employer shall recognize and deal with such representatives of the employees as the Union may elect or appoint and shall permit such representative elected or appointed by the Union to visit its plant at any time during working hours in accordance with existing rules.

Section 4. Records: The Employer agrees to make available to the Union such payroll records as the Union may reasonably require as the collective bargaining agent and/or contracting party hereunder.

ARTICLE II - TRIAL PERIOD AND UNION SECURITY

Section 1. Trial Period: All new inexperienced employees hired by the Employer shall have a trial period of six (6) weeks.

Section 2. Union Security: In the manner and to the extent permitted by law, membership in the Union on completion of the trial period of each employee, or on and after the thirtieth (30th) day following the date of execution of this Agreement, whichever is later, shall be required as a condition of employment of each employee; in the event that the trial period is less than thirty (30) days, membership of new employees shall not be required until thirty (30) days after the date of hire; all employees who are now members or hereafter become members of the Union shall, as a condition of continued employment, remain members during the term of this Agreement to the extent permitted by law.

ARTICLE III - WAGES

Section 1. Time rate and piece rate employees shall receive the wage increases set forth in Schedule A, attached hereto, and incorporated herein.

Section 2. Wages shall be paid in accordance with the schedule of wage rates as herein adjusted except that such schedule may be modified as expressly provided in this Agreement.

Section 3. In the event that any of the operations of the Employer are changed or new operations are added, piece rates for such operations shall be mutually agreed upon between the Union and the Employer and shall become effective as of the time that such operation is changed or new operation begun. The new piece rates shall maintain the average earnings of the employees prevailing at the time that the operation is changed or new operation begun. It is understood that the phrase "maintain the average earnings of the employees" refers to maintaining the average earnings of the Section and not to individual employees within the Section.

Section 4. If an employee is temporarily transferred from one job or operation to another at the request of the Employer, he shall, while working on the job or operation to which he has been transferred, be paid his average earnings prevailing at the time of the

transfer. The conditions to apply upon permanent transfer shall be mutually agreed upon by the Employer and the Union at the time of such transfer.

Section 5. Minima: The minimum wage rates for all employees shall be mutually agreed upon by the parties. However, no employee shall receive less than twenty-five cents ($0.25) per hour above the applicable federal or state minimum wage rate (whichever is higher) upon completion of the employee's probationary period.

Section 6. Pay Checks: Weekly pay checks shall show the number of hours which an employee has worked.

ARTICLE IV - HOURS OF WORK

Section 1. Basic Work Week: The regular work week for all employees shall be forty (40) hours, five (5) days per week, from Monday to Friday inclusive, of not more than eight (8) hours in any one (1) day. The daily schedule of hours shall be as agreed upon between the Employer and the Union.

Section 2. Overtime: Time and one-half shall be paid for all work outside the regular daily schedule of hours. No work shall be performed on a Saturday except by mutual agreement of the parties. Time and one-half shall be paid for all work performed on Saturdays irrespective of the number of hours worked during the week. No work shall be performed on a designated holiday or Sunday except by mutual agreement of the parties, and, if agreed upon, at double time. Overtime pay for work on a designated holiday shall be in addition to holiday pay to which the employee is entitled pursuant to the Article dealing with holidays.

Section 3. Notice of Overtime: The Employer agrees to give reasonable notice to the employees and the appropriate Union representative when overtime is to be worked.

Section 4. Overtime: Recognizing the importance for Employer to make timely shipments to customers to maintain the security of the industry, the Union agrees that upon request by the Employer it will work to address the Employer's overtime needs.

ARTICLE V - VACATIONS

Section 1. Vacation Period:

A. It is mutually agreed that there shall be the following vacation periods for employees entitled to vacation pay as hereinafter provided.

1. The Summer Vacation Period shall be two (2) consecutive weeks beginning with the last full week in the month of July in each year unless the Employer and the Union mutually agree upon some other two (2) consecutive weeks during the summer months.

2. The Christmas Vacation Period which shall be the week in which Christmas Day falls in each year.

3. Fourth Week of Vacation: Any employee with twenty (20) years, or more, of employment with the Employer or predecessor employers is entitled to a fourth (4th) week of paid vacation to be taken during the ensuing twelve (12) month period following the date that the employee reaches twenty (20) or more years of employment. The schedule of vacations by section shall be fixed by mutual agreement with the Union in accordance with the needs of production. Individual employees may bid for an available week in order of section seniority or such other rotational system as mutually agreed to with the Union. If mutually agreed to with the Union at the local level, an employee may elect to work during the employee's week of vacation at straight time in addition to vacation pay. The amount of time off and pay shall be the same as the preceding Winter Vacation.

4. In the event that a paid holiday falls within the vacation period, employees entitled to holiday pay shall be entitled to such holiday pay in addition to vacation pay hereinafter provided.

Section 2. Eligibility and Pay:

A. Employees employed prior to October 1, 1985;

1. For the Summer Vacation Period:

a. All employees who have been on the payroll of the Employer for at least six (6) months prior to the commencement of the Summer Vacation period and, except

as hereinafter provided, who are on such payroll at the commencement of the Summer Vacation Period are eligible for a paid vacation.

b. The amount of each employee's vacation pay for the Summer Vacation Period shall be determined in the manner set forth in this subparagraph. If the employee has been on the payroll of the Employer:

(1) Six (6) months but less than nine (9) months, he shall receive one-half (1/2) of one (1) week's pay,

(2) Nine (9) months but less than one (1) year, he shall receive three-fourths (3/4) of one (1) week's pay.

(3) One (1) year or more, he shall receive two (2) weeks' pay.

c. (1) First Week: In the case of hourly and weekly employees, one (1) week's pay shall be the employee's current regular weekly rate. In the case of piece work employees, one (1) week's pay shall be forty (40) times the individual employee's straight time average hourly earnings for the four (4) consecutive busiest weeks of the current vacation year beginning June 1st in the previous calendar year and ending May 31st in the current vacation year including the full amount of the wage increase paid on October 1, 2016, October 1, 2017 and October 1, 2018 as applicable. If an employee did not work in each of said four (4) weeks, his vacation pay shall be forty (40) times his straight time average hourly earnings for the four (4) busiest consecutive weeks of the vacation year in which he did work all four (4) weeks including the full amount of the wage increase paid on October 1, 2016, October 1, 2017 and October 1, 2018, as applicable.

(2) Second Week: An eligible employee who has worked not less than one thousand (1,000) hours in the twelve (12) months beginning June 1st in the previous calendar year and ending May 31st in the current vacation year shall receive for his second week's vacation pay the same amount as the employee's vacation pay for the first week.

For eligible employees who worked less than one thousand (1,000) hours during the entire aforesaid twelve (12) months period, the second week's vacation pay shall be two and one-half percent (2-l/2%) of the employee's straight time earnings in the twelve (12) months beginning June 1st in the previous calendar year and ending May 31st in the current vacation year.

2. For the Christmas Vacation Period:

a. All employees who have been on the payroll of the Employer one (1) year or more prior to December 1st and, except as hereinafter provided, who are on such payroll at the commencement of the Christmas Vacation Period are eligible for a paid Christmas vacation.

b. The amount of each employee's vacation pay for the Christmas Vacation Period shall be determined in the manner set forth in this subparagraph:

(1) An employee who has worked not less than one thousand (1,000) hours in the entire aforesaid twelve (12) months period,

(a) if an hourly or weekly employee he shall receive his current rate less three-quarters (3/4) of the wage increase paid on October 1, 2016, October 1, 2017 and October 1, 2018 as applicable,

(b) if a piece work employee, he shall receive forty (40) times his straight time average hourly earnings for the four (4) consecutive busiest weeks of the current vacation year, beginning December 1st in the previous calendar year and ending November 30th in the current vacation year, which average hourly earnings shall be adjusted by three-quarters (3/4) of the wage increase paid on October 1, 2016, October 1, 2017 and October 1, 2018 as applicable.

(2) An employee who worked less than one thousand (1,000) hours in the entire aforesaid twelve (12) months period shall receive two and one-half percent (2-l/2%) of his straight time earnings in the twelve (12) months

beginning December 1st in the previous calendar year and ending November 30th in the current vacation year.

B. Employees employed after October 1, 1985.

Each employee hired by the Employer on or after October 1, 1985 shall receive vacations with pay in accordance with the following requirements:

1. On completion of one (1) year of service, one (1) week vacation at the next ensuing regularly scheduled vacation period (either winter or summer, whichever comes first).

2. On completion of two (2) years of service, two (2) weeks of summer vacation except that an employee who first becomes eligible for two (2) weeks of vacation prior to the winter vacation shall receive one (1) week of winter vacation and one (1) week of summer vacation.

3. On completion of three (3) years of service, two (2) weeks of summer vacation and one (1) week of winter vacation.

Time off and pay for each week's vacation shall be determined by the applicable provisions of the existing agreement with respect to the employee's working time during the year.

Section 3. General Conditions:

A. An employee otherwise eligible for a paid vacation shall not be deemed ineligible because of the fact that he is temporarily laid off, ill, or in the Armed Forces of the United States at the commencement of the vacation period. The Impartial Arbitrator is expressly empowered to determine in accordance with the arbitration procedure provided in this Agreement whether an employee, discharged prior to the commencement of a vacation period, but otherwise eligible for a paid vacation, shall be entitled to vacation pay.

B. An employee who has been in the employ of the Employer a sufficient length of time to have earned a paid vacation as herein set forth, but whose employment has been

terminated because of termination of business or the closing of a plant, shall be entitled to vacation pay prorated as of the date of termination of employment.

C. Where an employee has been permanently and formally scheduled to work less than the regular work week for his operation, the eligibility and vacation pay schedule for such employee shall be adjusted pro-rata. The one thousand (1,000) hour requirement contained in Section 2, above, shall be similarly pro-rated.

D. Retired and Permanently Disabled Employees: Employees who, during any vacation year, retire under the terms of the Amalgamated Pension Plan or receive Old Age Social Security Retirement Benefits, or become totally and permanently disabled so as to become eligible for and subsequently receive disability insurance benefits pursuant to the Social Security Act, as amended, shall receive pro-rata vacation pay for the vacation year, measured from the commencement of the preceding vacation periods, summer and Christmas, to the date last worked. The vacation pay herein provided shall be paid upon presentation to the Employer of the Certificate of Eligibility issued by the Amalgamated Insurance Fund or the Certificate of Award issued by the Social Security Administration as appropriate.

E. Vacation pay as herein above provided shall be paid on the pay day immediately preceding the applicable vacation period.

F. For purposes of Section 2 above, employees who have completed a probationary period with an employer in contractual relations with the Union and who have been unemployed because of layoff or plant closing and who are re-employed in the same local market within one (1) year of loss of employment shall receive credit for each year of employment with the prior employer.

ARTICLE VI - HOLIDAYS

Section 1. A. 1. Subject to paragraph B. below all employees shall be entitled to the following eleven (11) holidays with pay:

New Year's Day
Good Friday
Washington's Birthday
Memorial Day
July 4th
Labor Day
National Observance of Martin Luther King, Jr.'s Birthday
Thanksgiving Day
Friday after Thanksgiving Day
Christmas Day
Last weekday prior to the commencement of Christmas Vacation

2. The Employer and the Union may by mutual agreement substitute a floating holiday for any of the fixed holidays so long as the total number of paid holidays remains the same. Existing holiday substitutions shall not be changed except by mutual agreement.

B. If a holiday falls within the initial trial period, the employee shall receive his holiday pay on the first full pay period following the successful completion of the trial period. If the employee does not complete the initial trial period for any reason no holiday pay is payable.

C. All such holidays shall be paid for irrespective of the day of the week on which the holiday falls.

Should any of the above holidays fall on Sunday, the day celebrated as such shall be considered the holiday.

Section 2. In the case of hourly and weekly employees, the pay for each holiday shall be one-fifth (1/5) of the employee's current regular weekly rate. In the case of piece workers the employee's pay for each holiday shall be eight (8) times the employee's straight time average hourly earnings as such earnings were computed for the purpose of determining the first week's vacation pay for the summer vacation period immediately preceding such holiday.

Section 3. Notwithstanding the provisions of this paragraph it is understood that holiday pay shall not be paid any employee if the Employer's factory is shut down in all his manufacturing departments for five (5) consecutive weeks as follows:

A. The entire two (2) weeks immediately preceding the week in which such paid holiday occurs; and

B. The entire week during which such paid holiday occurs; and

C. The entire two (2) weeks immediately following the week in which such paid holiday occurs.

Section 4. Any employee who is absent without reasonable excuse on the work day before or the work day after a holiday shall not be entitled to holiday pay. During the periods of extended illness, an employee shall be eligible upon his return to work for all of the holidays which occurred during a period not to exceed the first three (3) months of the illness. In determining whether an extended period of illness meets the requirements for the payment of holiday pay as outlined above, the employee must have been eligible for and have received disability insurance as provided for by Exhibit I of this collective bargaining agreement, and have returned to work promptly following the period for which such disability insurance was paid (except that when such disability insurance may have expired, a doctor's certificate shall be submitted for the period of time after the expiration of such disability insurance).

Where a holiday occurs within five (5) calendar days of the date of a death in the immediate family, the employee shall be eligible for holiday pay; provided that the employee informs the Personnel Department during this period of the death, giving the identity of the deceased, and his relationship to the employee. The immediate family for the purpose of this clause shall be limited to spouse, mother, father, children, brother, sister, grandparents, mother-in-law, father-in-law, sister-in-law and brother-in-law. The employee must bring with him, upon his return to work, evidence of the death, such as an obituary, death certificate, etc.

In order to establish the illness of an employee as a reasonable excuse for absence for the day before or the day after (or both) of a holiday, the employee must call in on the day or days of absence before 10:00 a.m. to the Personnel Department and explain the

reason for the absence. The Personnel Department may, at its option, call the home on the date of absence to ascertain that the employee is at home, or send a nurse to visit the home to verify the illness.

In order to establish the illness of a child as reasonable excuse for absence for the day before or the day after (or both) of a holiday, the employee must call in on the day or days of absence before 10:00 a.m. to the Personnel Department and explain the reason for the absence. Upon the employee's return to work, he must bring a doctor's certificate to the Personnel Department to verify the illness of the child. The Personnel Department may at its option, call the home on the date of absence to ascertain that the employee is at home, or send a nurse to visit the home to verify the illness.

Holiday pay shall not be paid until an employee returns to work or if the employee does not return to work promptly after the conclusion of an illness.

Except as mutually agreed to, employees while on a leave of absence are ineligible for holiday pay.

Section 5. Tandem or consecutive Holidays: The above "day before and after" rule shall apply to all holidays with the exception that should separate holidays fall either simultaneously or successively, an employee absent (without reasonable cause as heretofore defined) either the day before or the day after, shall lose only one (1) of the holidays. In the event an employee is absent (without reasonable cause as heretofore defined) both the day before and the day after, the employee shall lose holiday pay for all intervening holidays.

ARTICLE VII - EQUAL DIVISION OF WORK

Section 1. During any slack season or whenever there is insufficient work, except as provided for in Section 2. below, available work shall be divided, insofar as is practicable, equally among all regular employees of the Employer in order that continuity of employment may be maintained unless the Employer and the Union shall mutually agree upon a layoff and the conditions applicable thereto. It is understood that this clause has been mutually interpreted to provide for seniority of the employee as the basis for layoff.

Section 2. All cutting and trimming room employees classified as Cutters, Markers, Spreaders or Trimmers shall be given at least forty (40) hours work per week(It should not be construed as a guarantee of hours of work per week) unless specifically modified by mutual agreement of the parties. When there is no work for forty (40) hours per week for said cutting and trimming room employees, then probationary employees shall be laid off first followed by the least senior employee. The reverse procedure shall apply for recall.

ARTICLE VIII - PAYMENT OF WAGES AND CHECK-OFF

Section 1. The Employer agrees that he shall pay his employees on a prescribed day in each week.

Section 2. The Employer shall deduct from the wages of his employees upon written authorization of the employee's Union dues, initiation fees and assessments. The amounts deducted pursuant to such authorization shall be transmitted promptly each month to the properly designated official of the Union, together with a list of names of the employees from whom the deductions were made on forms to be provided by the Union. Sums deducted by the Employer as Union dues, initiation fees or assessments shall be kept separate and apart from the general funds of the Employer and shall be deemed trust funds.

As part of orientation process of new hires, the Employer will provide any new employee the Dues Authorization Card(s) provided by the Union. The Union and the Employer acknowledge Dues Authorization Cards are necessary in order for Union Dues to be deducted by the Employer, provided that if any employee will not execute such

Authorization Dues Cards there shall be no liability to the Employer. Should any new employee(s) refuse to execute the Dues Authorization Card(s), the Union Representative will be notified immediately.

The Employer shall provide for payroll deduction for all employees who voluntarily authorize such a deduction as a contribution to the Workers United for Political Power Campaign Committee, OR ANY SUCCESSOR THERETO. All payroll deductions to the Workers United for Political Power Campaign Committee shall be based on written authorization cards signed by the employee.

The Employer shall make the deduction for the Workers United for Political Power Campaign Committee for each payroll period or other designated work period worked by the employee who has authorized the deduction. Employer shall promptly transmit the amounts deducted from employee's paychecks for the Workers United for Political Power, Chicago & Midwest Regional Joint Board, 333 S. Ashland Ave. Chicago, IL 60607 accompanied by a CD or other computer-readable list of the names, addresses, and las four digits of social security numbers of all employees for whom a Workers United for Political Power deductions was made together with the date and amount of that deduction.

The Union shall indemnify, defend and save the Employer harmless against any and all claims, demands, suits, or other terms of liability that shall arise out of and by any reason of an action taken by Employer in reliance upon Workers United for Political Power payroll deduction cards submitted to the Employer.

Should the employees of the Employer agree to purchase additional insurance coverage provided by the Amalgamated Insurance Employer and/or Supplemental Insurance coverage provided by the Amalgamated Life and Health Insurance Employer, the Employer shall check off the employee's cost of the program, upon presentation of proper authorization, and pay the same over to the insurance Employer as required by the contract between the employees and the insurance Employer, as applicable.

ARTICLE IX - INSURANCE AND RETIREMENT

The Employer agrees to contribute monthly sum of money per employee for each Bargaining Unit Employee on payroll for said month as indicated in the Amalgamated National Health Fund Supplemental Agreement - Exhibit I. The Employer agrees to pay to Trustees a sum of money equal to the stated percentage of the Gross Wages payable for each pay period to all employees as indicated in the Amalgamated Social Benefits Association (Social benefits and Educational Assistance) Supplemental Agreement – Exhibit I.A. The Employer agrees to pay sums of money per employee for each Bargaining Unit as agreed and as indicated in the National Retirement Fund Supplemental Agreement – Exhibit II. Exhibits I, I.A and II, annexed hereto, the terms of said Exhibits I, I.A and II being specifically incorporated herein by reference.

ARTICLE X - UNION LABEL

The Employer agrees to affix copies of the Workers United Union to men's and boy's clothing including, without limitation, single pants manufactured by the Employer or by registered Union contractors on behalf of the Employer, all as provided in Exhibit III, annexed hereto, the terms and provisions of said Exhibit III specifically incorporated herein by reference. In addition thereto the Employer agrees that Size Ticket placed on each garment shall contain a legend to the effect that the same is manufactured by Workers United Union labor. The exact wording to be affixed on the Size Ticket shall be set by mutual agreement between the Clothing Manufacturers' Association of the United States of America and Workers United.

ARTICLE XI - MACHINE DOWN TIME AND WAITING TIME

An employee paid on a piece rate basis who is required to wait for work due to machine breakdown beyond his control shall be compensated at the rate of the employee's average hourly earnings for all such waiting time in excess of fifteen (15) minutes per day. An employee paid on a piece rate basis who is required to wait for work due to cause

beyond his control other than for machine breakdown shall be compensated at the rate of the employee's average hourly earnings for all such waiting time in excess of thirty (30) minutes per day. However, in no event will the combined unpaid machine down time and waiting time exceed thirty (30) minutes per day. Any employee who finds it necessary to wait for work shall, on each separate occasion, notify his immediate supervisor both at the beginning and end of such waiting period. Payment for waiting time shall cover only such time as follows such notification. The Employer may transfer such employees to another machine or job during waiting time. When transferred to another machine during machine down time, on the same job, the employee will be paid piece rate earnings.

ARTICLE XII - BEREAVEMENT PAY

A. An employee who has been on the payroll of the Employer for six (6) months or more shall be granted bereavement pay in the event of a death in the immediate family of the employee.

B. The immediate family is defined as father, mother, sister, brother, spouse, children, grandparents, grandchildren, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, and daughter-in-law.

C. Bereavement pay shall be based on the employee's daily time or piece rate earnings as established for the purpose of holiday pay.

D. Bereavement pay shall be paid for the day before, the day of and the day following the funeral when these days fall on days the employee would otherwise have worked. In the event that the death occurs outside the United States and notice thereof does not reach the employee until after the funeral, bereavement pay shall be paid for the three (3) days following receipt of notice provided that such days are days on which the employee would otherwise have worked.

E. No bereavement pay will be granted unless the employee notifies the Employer and requests leave. At his discretion, the Employer may require evidence of death and kinship.

ARTICLE XIII - REPORTING PAY

Employees who report for work at their regular starting time, or at such other hour designated by the Employer, shall be paid their established time or piece rate earnings for all work performed between the hour they report for work and the hour that they are dismissed, but in no event shall they be paid less than for six (6) hours, or four (4) hours on Saturday. This clause shall not apply in the event of power failure, fire or other cause over which the Employer has no control. In the case of the first five (5) hours of call-in pay, failure of other employees to report for work shall be considered cause over which the Employer has no control only if an emergency arises which it could not foresee and it had taken adequate steps to train and provide relief workers. Executive absenteeism shall relieve the employer of the obligation to pay the sixth (6th) hour of call-in pay.

ARTICLE XIV - NON-DISCRIMINATION

Section 1. The Employer and the Union shall not discriminate nor perpetuate the effects of past discrimination, if any, against any employee or applicant for employment on account of race, color, religion, creed, sex, or national origin. This clause shall be interpreted broadly to be coextensive with all federal, state or local anti-discrimination laws and where available, judicial interpretation thereof.

Section 2. Representatives of the Employer and the Union shall meet to review compliance with this provision and to mutually agree upon such steps as are necessary to achieve compliance. If, upon failure to so mutually agree, either party invokes the arbitration procedures of this Agreement to resolve the dispute, the Impartial Chairman shall fashion his award to grant any and all relief appropriate to effectuate this Article.

ARTICLE XV - MILITARY SERVICE

In the event that an employee enlists or is conscripted into the Armed Forces of the United States of America, or is called into service as a member of the National Guard or Army, Navy, Air Force, or Marine Corps Reserves, he shall, upon his discharge from service, be reinstated with all his rights and privileges enjoyed by him at the time he entered service, provided, that he shall request such reinstatement within the period fixed by law and provided that the Employer shall have the right to discharge any person whom he hired by reason of the entry into military service of the person to be reinstated.

ARTICLE XVI - OTHER FACTORIES AND CONTRACTORS; OUTSOURCING

Part One - Other Factories and Contractors:

Section 1. During the term of this Agreement the Employer agrees that he shall not, without the consent of the Union, remove or cause to be removed, his present plant or plants from the city or cities in which such plant or plants are located.

Section 2. During the term of this Agreement the Employer may, with the consent of the Union, manufacture garments or cause them to be manufactured in a factory other than his present factory or factories provided his factory or factories have full employment and provided further that such other factory or factories are under contract with the Union.

Section 3. The Employer further agrees that he shall send work only to such Union contractors designated by agreement of the parties herein. The Employer employing contractors agrees simultaneously with the execution of this Agreement to execute a contractor registration statement, the terms and conditions of which shall be specifically incorporated herein by reference.

Section 4. It is agreed that imports other than corduroy clothing not made in Union shops, are within the scope of Article XVI. The Employer shall notify the Union of its intentions as to such corduroy clothing, and the quantities involved and shall make available to the Union all pertinent documentation involved in such transaction. In the

event corduroy clothing becomes an important production item in shops under contract with the Union, this exception to Article XVI shall be subject to renegotiation upon reasonable notice from the Union. Then existing commitments shall not be interfered with.

Part Two - Outsourcing:

Section 1. Permissible Outsourcing.

During the term of this Agreement and subject to all of the conditions contained herein the Employer shall be permitted to outsource no more than 22% of its current contract year's production each year during the term of this Agreement. The remaining percentage of each year's production is to be manufactured in its facilities covered by this Agreement. Outward processing production (known as "807" or "807 A" production) will be defined as outsourced products. Further, outsourcing will not excuse the participating firm from making needed investment in its domestic facilities and equipment. Any Employer who outsources hereby commits to invest in improved physical plant, equipment and EDI systems in its own facilities. These "outsourcing" provisions do not apply to production sourced to domestic facilities within the United States. Such production is governed by the "Other Factories and Contractors" provisions contained in Part One of this Article XVI.

For the purpose of this Article, "current contract year" shall mean the period between October 1 and September 30.

Section 2. Notification.

The Employers must give the Union advance notification of its planned outsourcing. Said notification shall include:

1. The number and types of units the Employer plans to outsource;
2. The reasons why the outsourcing is planned;
3. The name and location of the source.

The Union shall have the opportunity to find a suitable alternative source within one (1) week of said notice.

Section 3. Guarantees.

If, during the term of this Agreement, an Employer outsources more than an experimental level of production it shall, for each contract year during which it outsources, guarantee that its current full-time employees work at least 1,470 hours, in addition to vacations and holidays during said contract year. An experimental level of production is defined as the greater of one thousand (1,000) units or two per cent (2%) of the domestic production in the preceding contract year to a maximum of three thousand (3,000) units.

For the purpose of this Agreement, a suit or overcoat/topcoat should count as one (1) unit; a coat as two-thirds (2/3) of a unit; a pair of pants as one-third (1/3) of a unit and a vest as one-sixth (1/6th) of a unit.

Such hours as are not worked: (1) at the option of the employee or because the employee is not available for employment, (2) because of power failure, fire or other cause over which the firm has no control as defined in the Reporting Pay provision of the Collective Bargaining Agreement (but not including short time for lack of sales), and (3) hours otherwise compensated for pursuant to the firm's Collective Bargaining Agreement with the Union, shall be counted toward fulfilling the guarantees.

For each unit outsourced pursuant to this Agreement, the Employer shall pay: (1) one dollar ($1.00) per unit for all units outsourced below 10%; (2) $1.50 per unit for all units outsourced between 10% and 15% and (3) $1.75 per unit for all units outsourced in excess of 15% divided among all of the employees of the Employer on the payroll as of the beginning and the end of the contract year, as a holiday bonus, not later than December 15 following the end of each contract year for which the Employer is required to make such payments pursuant to the outsourcing agreement. This payment, if the employee so elects, may be made by the Employer to the National Plus 401(k) program which will make such arrangements as are necessary to receive said payments.

An Employer electing to participate in an outsourcing program shall so notify the Joint Board Manager and the Union's International President with respect to the planned outsourcing by certified mail, RRR. The Union's one (1) week period to find a suitable alternative to the outsourcing shall begin to run upon earliest receipt of that notice. All

reports and information required by the National Agreement with respect to the outsourcing program shall be made to the Joint Board Manager and to the Union's International President.

Section 4. Shipping.

The Firm shall receive and ship all units subject to this Article only in facilities under contract with the Union.

Section 5. Records.

The Union shall be provided such records as are required to monitor compliance with the terms of this Article, in addition to all other rights with respect to inspection of records guaranteed to it under the Collective Bargaining Agreement. The information shall be kept confidential. Any breach of such confidentiality shall terminate the right of the Union to examine such records upon the decision of an arbitrator that the Union did indeed breach the confidentiality agreement.

Section 6. Continuation of Contracting.

Unless the Employer brings work, that had been performed by its existing contractors, into its facilities covered by this Agreement, it shall during any contract year in which it outsources production continue to supply work to contractors at such levels as supplied in the previous year. Contractors shall include all contractors of shoulder pads, coats fronts, sponging and examining, to the extent now contracted. The measure of damages payable to the Union for failure to supply the amount of work required by the preceding sentence shall be that applied to other violations of this article.

Section 7. Damages.

Claims that any Employer is in violation of this Article shall be resolved through the grievance and arbitration provisions of this Agreement. If the Arbitrator finds that the Employer has violated this Article by outsourcing in excess of the limits set forth herein, the Arbitrator shall impose damages equal to one and one-half (1-l/2) times the unit labor cost of these outsourced units in excess of the limit. Said damages shall be paid to the Joint

Board that is party to an Agreement with the Employer for distribution to the affected employees.

Standards: It is agreed that all Employers will comply with the following work standards in any outsourcing:

Wages: Employer will only do business with partners, contractors or other sources who provide wages and benefits that comply with any applicable law and provide a living wage defined as a specified market-basket of consumer goods priced in local currency and adjusted for inflation in the country from which the product is being sourced.

Working Hours: Employer will only do business with partners, contractors or other sources outside the United States that comply with all applicable laws and will not utilize a source who requires more than a forty-eight (48) hours work week and does not provide at least one (1) day off in each seven (7) days.

Forced or Compulsory Labor:

In the manufacture of its products, Employer will not work with business partners that use forced or other compulsory labor, including labor that is required as a means of political coercion or as punishment for holding or for peacefully expressing political views. Employer will not purchase materials that were produced by forced, prison or other compulsory labor and will terminate business relationships with any sources found to utilize such labor.

Child Labor:

Employer will not work with business partners that use child labor. The term "child" generally refers to a person who is less than 14 years of age, or younger than age for completing compulsory education if that age is higher than 14. In countries where the law defines "child" to include individuals who are older than 14, Employer will apply that definition.

Freedom of Association:

Employer will use business partners that share a commitment to the right of employees to establish and join organizations of their own choosing and abide by international standards as specified by the ILO regarding freedom of association.

Employer will assure that no employee is penalized because of his or her exercise of this right. Employer recognize and respect the right of all employees to organize and bargain collectively, and to strike.

Discrimination:

Employer will not use business partners who discriminate on the basis of personal characteristics rather than people's ability to do the job. They will not utilize partners who use corporal punishment or other forms of mental or physical coercion.

Safe and Healthy Work Environment:

Employer will have business partners that provide employees a safe and healthy workplace and that do not expose workers to hazardous conditions.

Continued Violators:

If the Union determines that countries or Employer have repeatedly violated the foregoing work standards or are pervasive violators of human rights, it shall notify the Employer and give it sixty (60) days to remedy the violations. If the Union chooses it may take the alleged violations to binding expedited arbitration. If the Union proves its case, the Employer shall cease to contract with that country or Employer.

Monitoring:

Employers and Chicago & Midwest Regional Joint Board, Workers United shall periodically monitor the compliance of their contractors/suppliers with the above standards and reports of this monitoring will be made available to the other party.

Part Three:

It is agreed that the Joint Board, with the approval of the National Office, may agree to amend the outsourcing provisions of this Agreement as they apply to a particular

Employer. Any practice previously adopted on a local level, that relates to outsourcing, shall be continued by the parties and shall be reduced to writing as an amendment to this Agreement.

ARTICLE XVII - HOMEWORK

None of the Employer's work may be performed in the homes of the employees.

ARTICLE XVIII - DISCHARGES

The full power of discharge and discipline lies with the Employer. It is agreed that this power shall be exercised with justice and due regard to the reasonable rights of the employee. No employee covered by this Agreement shall be discharged without sufficient cause. The power of discharge shall be exercised only through the duly authorized and responsible representative of the Employer. If the Union, after investigation, finds that an employee has been discharged without just cause it shall present a complaint with references to the discharge to the Employer within seven (7) days after the discharge. If the complaint cannot be adjusted by mutual consent between the representatives of the parties it may be submitted, by either party to the Impartial Arbitrator for determination pursuant to the procedure provided. If the Impartial Arbitrator finds that the employee was discharged without sufficient cause, he shall order reinstatement and may require the payment of back pay as in his judgment the circumstances warrant. This paragraph shall not apply to an employee during his trial period.

ARTICLE XIX - GRIEVANCE AND ARBITRATION

Section 1. Any complaint, grievance or dispute arising under, out of, or in connection with or relating directly or indirectly to the provisions of this Agreement (including the agreements which are Exhibits I, IA, II, and III) or interpretation or performance thereof, shall in the first instance be taken up for adjustment by a representative of the Union and a representative of the Employer. Any and all matters in dispute, including a dispute concerning the interpretation or application of the arbitration provision, which have not been adjusted pursuant to the procedure therein provided, shall

be referred for arbitration and final determination upon written notice from the Manager of the Union to the Employer or from the Employer to the Manager of the Union, such matter shall be referred to an Impartial Arbitrator selected as follows:

Section 2. The parties designate Dr. Phillip Ross as the impartial chairman. In the event of the inability of the said Dr. Phillip Ross, Roger Maher shall serve as Impartial Chairman during the unavailability of Dr. Ross.

Section 3. The expenses of arbitration and of the Impartial Arbitrator shall be borne equally between the parties.

Section 4. Except as expressly provided otherwise in this Agreement, with respect to any dispute subject to arbitration or any claim, demand, or act arising under the Agreement which is subject to, the procedure established in this Agreement for the adjustment thereof shall be the exclusive means for the determination of such disputes. No proceedings or action in a court of law or equity or administrative tribunal shall be initiated with respect thereto other than to compel arbitration or to enforce, modify or vacate an award. This section shall constitute a complete defense to or ground for a stay of an action instituted contrary hereto.

ARTICLE XX - STOPPAGE AND LOCKOUTS

The Employer and the Union agree that there shall be no stoppages or lockouts during the term of this Agreement. In the event, however, that either party fails to comply with the decision or award of the Impartial Arbitrator, in accordance with the provisions of Article XIX above, within ten (10) days after service of a copy thereof, the other party shall be immediately free to call a strike, stoppage or lockout as the case may be.

ARTICLE XXI - JURY DUTY

An employee called for involuntary trial jury duty will be paid the difference between the pay received for such jury duty and his straight time average weekly earnings (calculated for the eight (8) weeks immediately preceding such jury duty) for the period of such jury duty. The employee shall present a receipt for the amount of jury duty pay received. An employee who receives a notice to serve as a juror must notify his Employer not later than the next work day. If the Employer deems it necessary to have the employee excused from jury duty, the Union and the employee agree to cooperate in seeking to have the employee excused.

ARTICLE XXII - MORE FAVORABLE PRACTICES

Any custom or practice existing in the plant of the Employer at the time of the execution of this Agreement more favorable to the employees than the provisions hereof shall be continued as heretofore. It is understood that this clause is to be mutually interpreted to provide that prior contrary past practices do not prevail over subsequently negotiated contract provisions, such as Section 4 of Article XXIV.

ARTICLE XXIII - SUCCESSORS

In the event the Employer merges or consolidates with, or its business is acquired by another person, firm or corporation, the Employer shall remain bound by all of the terms and provisions of this Agreement for the full term hereof.

ARTICLE XXIV - INTRODUCTION OF TECHNOLOGICAL CHANGES, ETC.

Section 1. The Union has long cooperated with Employers in the introduction of new machinery, changes in manufacturing techniques, and technological improvements in clothing plants. This policy has been established by mutual agreement between the Employer and the Union. Underlying such agreement has been the recognition of these basic conditions: (a) wages of the affected workers were not to be reduced; and (c) workers were not to be thrown out of employment. Such policy is reaffirmed.

Section 2. If, however, in the event that the introduction of any such new machinery, changes in manufacturing techniques and technological improvements would not, in the opinion of either party, be consistent with the maintenance of the aforesaid basic conditions, then the parties shall study and seek to resolve the problems attendant upon such change.

Section 3. Subject to the foregoing basic conditions (a) and (b) of Section 1 above, the scope of the general arbitration clause shall remain in full force and effect and applicable to all covered by this Agreement.

Section 4. To provide for reasonably comparable implementation of the basic conditions set forth in Article XXIV, including the definition of technological change, the Employer and the Union shall utilize the following guidelines in the absence of mutually satisfactory guidelines heretofore established on a market or local union level. Where an Employer contemplates such a technological change, the Employer shall give prior notice to the Union. Rates for such newly introduced or changed machinery shall be established by mutual agreement. While employed on the newly introduced or changed machinery, a worker shall be paid wages earned plus the difference, if any, between the expected earnings under the newly established rate and his prior earnings. Workers in the affected operation shall not be thrown out of employment, instead, if a job is available on a substantially equivalent operation, with the opportunity for substantially equivalent earnings, a worker may be transferred to such job and, during a period of retraining equal

to the normal training period for similarly experienced workers, shall be guaranteed his former average hourly earnings. If such a job is not available, the workers shall have the option of (a) accepting another job with a guarantee, during a period of retraining equal to the normal training period for similarly experienced workers, of his former average hourly earnings, or (b) severance pay in such amounts as shall be mutually agreed to by the Employer and the Union. A worker electing to take a job which is not on a substantially equivalent operation with the opportunity for substantially equivalent earnings may subsequently elect to take severance pay, in which event such severance pay shall be reduced by any make-up pay paid pursuant to the normal training program applied. In the event the worker elects to take severance pay, such worker shall retain for one (1) year his seniority and recall rights to his former job or section.

ARTICLE XXV - LEAVE

Section 1. Leaves of absence shall be granted for justifiable personal reasons. The Employer may limit the number of leaves for personal reasons granted at any time to avoid an unreasonable effect on the Employer's ability to operate. Such leaves may be limited to an initial period of two (2) weeks with extensions granted by mutual agreement. All other leaves shall be granted for such periods and under such circumstances as have been heretofore granted.

ARTICLE XXVI - SEPARABILITY

Should any part or provision of this Agreement be rendered or declared illegal by reason of any existing or subsequently enacted legislation or by any decree of a court of competent jurisdiction or by the decision of any authorized government agency, such invalidation of such part or provision shall not invalidate the remainder thereof. In such event, the parties agree to negotiate substitute provisions.

ARTICLE XXVII - SAFETY AND HEALTH STUDY COMMITTEE

A Safety and Health Study Committee will be established in each plant. It will meet regularly at dates, times, and places to be determined by local management after consultation with the Union. The employees shall be paid their established time rate or piece rate average by the Employer while attending such meetings.

ARTICLE XXVIII - ORGANIZATIONAL HIRING

The Employer agrees that it will hire employees who have been discharged from other employers during an organizing campaign conducted by the Union. The Employer is not required by this Section to hire an employee who is not qualified to perform the job that is being applied for.

The Employer is not required to employ such applicants if it does not have jobs available. Any employee hired under this Section is subject to the Employer's regular probationary period for new employees.

The Employer is not required to unlawfully give preference to employees applying under this Section.

The Union will hold the Employer harmless for any liability, including but not limited to attorney's fees, imposed by enforcement of this clause.

ARTICLE XXIX - MORE FAVORABLE CONDITIONS

If the Union enters into any agreement with any manufacturer of Men's and/or Boy's tailored clothing which has previously resigned from the CMA and which provides any terms or condition more favorable to that employer than any term or condition contained in this agreement then upon written notice given by the Clothing Manufacturers Association of the United States of America, Inc., such terms or conditions shall automatically be extended to the Employer members of the Clothing Manufacturers

Association of the United States of America, Inc. who are parties to and covered by this agreement. Such employer members of the Clothing Manufacturers Association of the United States of America, Inc. shall have the right to make such terms or conditions retroactive to the effective date of such terms or conditions in the agreement containing such more favorable terms or conditions.

ARTICLE XXX - TERM OF AGREEMENT

This Agreement shall be effective upon the date hereof and shall remain in full force and effect until midnight September 30, 2019. It shall be automatically renewed from year to year thereafter unless on or before July 30, 2019 or July 30, of any year thereafter, notice in writing by certified mail is given by either the Employer or the Union to the other of its desire to propose changes in this Agreement or of intention to terminate the same, in either of which events this Agreement shall terminate upon the ensuing midnight September 30.

IN WITNESS WHEREOF, the parties hereto have caused their signatures to be affixed effective the day and year herein above written.

OXXFORD CLOTHES, INC

By: _____

Title: CFO

CHICAGO & MIDWEST REGIONAL JOINT BOARD, affiliated with Workers United/SEIU

By: _____

Title Union Representative

CLOTHING

SCHEDULE "A"

A. WAGE INCREASES:

1. TIME RATE EMPLOYEES

a. Effective October 1, 2016, the Employer shall grant a wage increase of twenty-five cents ($ 0.30) per hour to all time rate employees.

b. Effective October 1, 2017, the Employer shall grant a wage increase of twenty-five cents ($0.30) per hour to all time rate employees.

c. Effective October 1, 2018, the Employer shall grant a wage increase of twenty-five cents ($0.35) per hour to all time rate employees.

2. PIECE RATE EMPLOYEES

a. Effective October 1, 2016, the Employer shall incorporate into all existing piece rates a wage increase of thirty cents ($0.30) per hour.

b. Effective October 1, 2017, the Employer shall incorporate into all existing piece rates a wage increase of thirty cents ($0.30) per hour.

c. Effective October 1, 2018, the Employer shall incorporate into all existing piece rates a wage increase of thirty-five cents ($0.35) per hour.

3. TARIFF BONUS

a. In the event the Employer shall receive a rebate or tariff reduction for duties paid on imported woolen or worsted fabrics by December 1, 2016, each bargaining unit active employee on the payroll on both December 1, 2015 and December 1, 2016, and each retiree or early retiree who has retired since December 1, 2015, who was an active employee on December 1, 2015, will receive a bonus of $100.00. This bonus is to be paid no later than December 15, 2016.

b. Should the present rebate and refund program be extended beyond 2016, and the event that the Employer shall receive a rebate or tariff reduction for duties paid on imported woolen or worsted fabrics by December 1, 2017, each bargaining unit active employee on the payroll on both December 1, 2016 and December 1, 2017, and each retiree or early retiree who has retired since December 1, 2016, who was an active employee on December 1, 2016, will receive a bonus of $100.00. This bonus is to be paid no later than December 15, 2017.

c. Should the present rebate and refund program be extended beyond 2017, and the event that the Employer shall receive a rebate or tariff reduction for duties paid on imported woolen or worsted fabrics by December 1, 2018, each bargaining unit active employee on the payroll on both December 1, 2017 and December 1, 2018, and each retiree or early retiree who has retired since December 1, 2017, who was an active employee on December 1, 2017, will receive a bonus of $100.00. This bonus is to be paid no later than December 15, 2018.

d. All the bonuses to be paid hereunder shall be paid in the form of a separate check, and only applicable Social Security and Medicare payroll taxes are to be withheld. If for any reason, not under control of a Employer, the refund due will not be received prior to December 1of the applicable year, the Employer will pay the bonus thirty (30) days after receipt of such refund. It is understood that employers that do not receive a duty refund will not be obligated for this bonus.

e. No fringes will be payable on the above benefits, which will not be defined as included in the phrase "gross wages" for the purpose of any insurance or pension contributions.

Exhibit #I

AMALGAMATED NATIONAL HEALTH FUND

SUPPLEMENTAL AGREEMENT DATED AS OF AUGUST 1, 2017 between OXXFORD CLOTHES, INC. (herein called the "Employer") and the CHICAGO & MIDWEST REGIONAL JOINT BOARD, WORKERS UNITED (herein called the "Union") and the AMALGAMATED NATIONAL HEALTH FUND (herein called "the Fund") (THE SUPPLEMENTAL AGREEMENT)

WITNESSETH:

WHEREAS, the Employer and the Union have heretofore executed a Collective Bargaining Agreement (herein called the "Collective Bargaining Agreement") which is now in full force and effect and may be amended from time to time, and

WHEREAS, as part of the consideration for the execution, renewal or extension of the Collective Bargaining Agreement by the Union, the Employer agrees to contribute sums of money to a fund or funds to be used to provide health and welfare benefits, as established by the Trustees of the Fund, to employees employed by the Employer who are members of the bargaining unit covered by the Collective Bargaining Agreement (the "Bargaining Unit Employees"), and

WHEREAS, the Trustees of the Fund are authorized by the Agreement and Declaration of Trust of the Fund, as amended (the "Trust Agreement"), to approve an employer's participation in the Fund pursuant to an agreement executed by the Fund and the employer, and

NOW, THEREFORE, the Union and the Employer agree that the Collective Bargaining Agreement shall be supplemented as follows:

1. The Employer shall pay to the Fund all contributions for Bargaining Unit Employees as follows:

A. Contributions shall be the monthly sum per employee for each Bargaining Unit Employee on the payroll for said month as indicated below:

GOLD PLUS PLAN RATES

COMMENCING AUGUST 1, 2017

Coverage Options	Total Rate
Employee only	**$ 576.00/mo.**
Employee/Spouse	**$1,283.00/mo.**
Employee/Child	**$ 778.00/mo.**
Employee/Children	**$1,065.00/mo.**
Family	**$1,628.00/mo.**

GOLD PLUS PLAN RATES

COMMENCING OCTOBER 1, 2017

Coverage Options	Total Rate
Employee only	**$ 622.00/mo.**
Employee/Spouse	**$1,386.00/mo.**
Employee/Child	**$840.00/mo.**
Employee/Children	**$1,150.00/mo.**
Family	**$1,758.00/mo.**

GOLD PLUS PLAN RATES

COMMENCING OCTOBER 1, 2018

Coverage Options	Total Rate
Employee only	**$ 671.00/mo.**
Employee/Spouse	**$1,497.00/mo.**
Employee/Child	**$907.00/mo.**
Employee/Children	**$1,242.00/mo.**
Family	**$1,898.00/mo.**

In the event of a conflict betw een the above contribu tions rates and dates and the Collective Bargaining Agreement, this Supplemental Agreement shall control.

B. Contributions each month must be received by the Fund no later than the 1st business day of the month following the month of coverage with a statement listing the Bargaining Unit Employees for whom payment is made or as otherwise required by the Fund's collections and delinquency policy as it may be amended from time to time, which is specifically incorporated in this Supplemental Agreement by reference.

C. If the payment is not timely received the coverage for the Bargaining Unit Employees may be terminated as of the first day of the month of non-payment without any further notice.

2. All of the foregoing sums shall be administered and expended by the Fund pursuant to the provisions of the Trust Agreement for the purpose of providing health and welfare benefits as the Fund may reasonably determine to Bargaining Unit Employees, employees employed by other Employers, and such other persons covered by agreements with the Fund, all of whom are participants or beneficiaries of the Fund's plan of benefits (the "Plan"). The terms and provisions of the Trust Agreement as it may be amended from time to time are herein specifically incorporated in this Supplemental Agreement by reference.

3. A. The Employer shall furnish to the Fund, upon request, such information and reports as the Fund may require. The Employer agrees to comply with the Fund's COBRA procedures, and any other policies or procedures (e.g., the collections and

delinquency policy, audit policy, etc.), as such may be amended from time to time, which are specifically incorporated in this Supplemental Agreement by reference, including the obligation to provide the Fund timely written notice after any of its employees participating in the Fund (i) dies, (ii) is terminated from employment, or (iii) any employee or his/her spouse or other dependent otherwise ceases to be eligible to participate in the Fund. The Employer agrees that the Employer shall be liable for all liabilities, including, but not limited to, contributions due through the month when the Employer reported to the Fund the COBRA qualifying event and COBRA penalties for failure to provide the Fund with timely notification of a COBRA qualifying event. The Employer recognizes that the Fund will terminate participation of participants or beneficiaries based on when the Employer reports the termination event and not when the event occurred (e.g., if the Employer terminated the employment of an employee in January, but did not report the termination to the Fund until April, the Employer will owe contributions through April and the former employee will continue to be a participant in the Fund through April although the former employee stopped working in January). The Fund, or any authorized agent or representative of the Fund, shall have the right at all reasonable times during business hours to enter upon the premises of the Employer and to examine and copy such of the books, records, papers and reports of the Employer as may be necessary to permit the Fund to determine whether the Employer is fully complying with the provisions of this Agreement.

B. In the event that the enrollment of Bargaining Unit Employees is performed by a third party, and not by the Employer, the third party will provide to the Employer and the Fund a monthly list of Bargaining Unit Employees enrolled in the Plan. In the event the Employer asserts it has no obligation to make contributions to the Fund for anyone named on such list, it will notify the Fund and the third party within ten (10) days of receipt of the list provided by the third party.

4. No employee shall have the option to receive instead of the benefits provided for by the Trust Agreement or Plan any part of the contribution of the Employer. No employee shall have the right to assign any benefits to which he or she may be or become entitled under the Trust Agreement or Plan, or to receive a cash consideration in lieu of such benefits either upon termination of the trust therein created or through severance of employment or otherwise.

5. A. This Supplemental Agreement, the Collective Bargaining Agreement, the Plan and the Trust Agreement shall be construed as a single document, provided however that any controversy, claim, complaint, grievance or dispute arising out of or relating to the provisions of this Supplemental Agreement or the interpretation, breach, repudiation, application or performance thereof, may be referred by the Union, the Fund or the Employer for arbitration and determination as hereinafter provided:

(1) Ralph S Berger, Esq., or his designee, is designated as the Arbitrator under this Supplemental Agreement. In the event of the unavailability of Ralph S Berger, Esq., or his designee, a successor Arbitrator shall be appointed in writing by the Employer, the Fund and the Union. In the event they cannot agree on a successor, the Arbitrator shall be appointed forthwith by the American Arbitration Association upon application of the Fund, the Union or the Employer.

(2) The powers of the Arbitrator and the procedures for Arbitration hereunder shall be as hereinafter provided. The decision, order, direction, award or action of the Arbitrator shall be final, conclusive, binding and enforceable in a court of competent jurisdiction.

B. In addition to the powers which the Arbitrator may possess pursuant to the within Supplemental Agreement or by operation of law, in the event of any breach or threatened breach of this Supplemental Agreement, the Arbitrator, after a hearing, may issue an award providing for a mandatory direction or prohibition.

C. The parties consent that any papers, notices or processes, including subpoenas, necessary or appropriate to initiate or continue an arbitration hereunder or to enforce, confirm, vacate or modify an award, may be served by certified mail directed to the last known address of the Employer, the Union and the Fund.

D. The Union or the Employer or the Fund may call such arbitration hearing by giving five (5) days notice by certified mail or two (2) days notice by email to the other parties. The Arbitrator, however, if he deems it appropriate, may call a hearing on shorter notice. The parties consent that arbitration hearings shall be heard at such place as the Arbitrator may designate.

E. The parties agree that the oath of the Arbitrator is waived and consent that he may proceed with the hearing on this submission. In the event a party to arbitration should default in appearing before the Arbitrator, the Arbitrator is hereby empowered to take the proof of the party or parties appearing and render an award thereon.

F. The Employer's pertinent books, vouchers, papers and records shall be available for examination by duly authorized representatives of the Arbitrator to determine whether there is full compliance with the terms of this Supplemental Agreement.

G. The Arbitrator shall order the Employer to pay all insurance related claims to the extent of the schedule of benefits established from time to time by the Fund, which arise during any period of suspension or cancellation of insurance coverage caused by non-payment by the Employer of the required contributions to the Fund, and which claims remain unpaid because of said non-payment.

H. The Arbitrator shall include in the award against the Employer the reasonable costs of collection, including, but not limited to, the Arbitrator's fees, legal fees, interest, liquidated damages, auditing and accounting costs; providing, however, that no costs of collection shall be awarded against the Employer unless the said award shall also find that the Employer has failed to perform and comply with the terms and provisions of this Supplemental Agreement.

I. The Fund, in its own name may institute or intervene in any proceeding at law, in equity, in bankruptcy or arbitration proceedings for the purpose of effectuating the collection of any sums due to it from the Employer under the provisions of paragraph 1.

J. In the event the Union receives written notice from the Fund that the Employer has failed to pay in full any sum due the Fund under paragraph 1 and that such failure has continued for five (5) days, the Union may direct its members to discontinue work in the plant of the Employer and to discontinue work upon apparel being manufactured for the Employer by contractors until all sums due from the Employer under paragraph 1 above have been paid in full. The remedy provided for in this sub-paragraph shall be in addition to all other remedies available to the Union and the Fund, and may be exercised by the Union, anything in the Collective Bargaining Agreement or the within Supplemental Agreement to the contrary notwithstanding. Payment by the Employer under protest shall be without prejudice to its right to contest the correctness of the Fund's demand.

6. The provisions of this Supplemental Agreement shall remain in full force and effect for the full term of the Collective Bargaining Agreement and of any extensions or renewals thereof including during negotiations for a successor Collective Bargaining Agreement, but shall terminate and come to an end if (a) the Collective Bargaining Agreement is amended to no longer require participation in the Fund; (b) the employer is no longer required to contribute to the Fund by operation of law; or (c) at any time determined by the Trustees of the Fund. The Employer and the Union shall provide to the Fund copies of any extensions or renewals of the Collective Bargaining Agreement.

7. In no event will the Employer be entitled to the return of any part of any contribution made hereunder except as provided by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

8. This Supplemental Agreement shall be governed by and construed and enforced in accordance with the ERISA, and to the extent not preempted by federal law, the laws of the State of New York, without regard to choice of law provisions.

9. Regardless of the date on which the within Supplemental Agreement shall be executed, the within Supplemental Agreement shall be effective as of JANUARY 1, 2017, with the same force and effect as if it had been actually executed on that date.

10. Neither the execution of this Supplemental Agreement nor any provision herein contained shall be deemed to release the Employer from any contribution or contributions provided for in any prior agreement or agreements, and which have become due and payable to the Fund referred to in any such prior agreement or agreements, prior to JANUARY 1, 2017 and not yet paid to the Fund.

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Agreement to be executed by their duly authorized representatives as of the day and year first above written.

Billing # 2028483
Employer # 1028589

OXXFORD CLOTHES II, INC.

By: Steven D

CFO
Title

CHICAGO & MIDWEST REGIONAL JOINT BOARD, WORKERS UNITED

By: Margarita Alvarez

union representative
Title

Address of Employer:

5635 SOUTH ARCHER AVE., UNIT 2
Street

CHICAGO, IL 60638
City, State and Zip

AMALGAMATED NATIONAL HEALTH FUND
by Alicare, Inc.

By:

Title

- Exhibit I.4

AMALGAMATED SOCIAL BENEFITS SUPPLEMENTAL AGREEMENT

SUPPLEMENTAL AGREEMENT, dated March 1, 2017, and entered into by and between **OXXFORD CLOTHES, INC.** (hereinafter referred to as "Employer") and **CHICAGO & MIDWEST REGIONAL JOINT BOARD, affiliated with Workers United/SEIU**(hereinafter referred to as "Union").

WITNESSETH

WHEREAS, Employer and Union have heretofore or concurrently herewith executed a collective bargaining agreement (hereinafter referred to as "Collective Bargaining Agreement"), which is now in full force and effect; and

WHEREAS, as part of the consideration for the making of the Collective Bargaining Agreement, Employer has agreed to enter into this Supplemental Agreement;

NOW, THEREFORE, Employer and Union agree that the Collective Bargaining Agreement shall be supplemented as follows:

1. Wherever used in this Supplemental Agreement, the following terms shall have the following meanings:

(a) "Employee" means all employees in the bargaining unit covered by the Collective Bargaining Agreement, including employees who have not completed their trial period, if any; and "employee" means a single such employee, unless otherwise indicated.

(b) "Trust Agreement" means the Trust Agreement dated March 1, 1940, creating Amalgamated Social Benefits Association, as now or hereafter amended.

(c) "Trustees" means the present trustees, and their successors, under the Trust Agreement, unless otherwise indicated.

2. Commencing on the payday for Employer's pay week which includes **March 1, 2017,** and monthly thereafter during the term of this Supplemental Agreement. Employer shall pay to Trustees a sum of money equal to the following percentage of the **Gross Wages** payable for each pay period to all employees.

- **Effective 03/1/17 – 2.3% of Gross Wages**
- **Effective 10/1/17 – 2.5% of Gross Wages**
- **Effective 10/1/18 – 3.0% of Gross Wages**

"**Percentage of Gross Wages**" as used herein, means all monetary compensations of every kind, type and sort whatsoever, for all hours worked and paid **for each period to all employees**, before any deductions.

3. All sums payable to Trustees under this Supplemental Agreement shall be transmitted to Trustees promptly upon becoming due, and shall be administered and expended by Trustees pursuant to the provisions of the Trust Agreement for the purpose of providing employees (jointly with the employees of other employers) with forms of medical care at the Sidney Hillman Health Centre, educational assistance and other social benefits, and members of employees' families (jointly with members of families of employees of other employers) with social benefits, and such other benefits for employees and/or members of employees' families, and in such amounts, as Trustees may, in accordance with applicable law and the provisions of the Trust Agreement, from time to time in their discretion decide upon.

4. In the event that Employer fails to pay in full any sum due Trustees hereunder, and such failure continues for five (5) days after notice to the employer, Union may direct its members to discontinue work in Employer's plant until all sums due from Employer hereunder have been paid in full. The remedy provided for in this paragraph shall be in addition to all other remedies available to Union and Trustees and may be exercised by Union, anything in the Collective Bargaining Agreement to the contrary notwithstanding. Payment by the Employer under protest shall be without prejudice to the right to contest the correctness of the demand.

5. Should a claim, controversy, complaint, grievance or dispute arise out of or related to the provisions of this Supplemental Agreement or the interpretation, breach, repudiation, application or performance thereof, then it shall be referred by the Union, the Trustees or the Employer to arbitration for determination. In addition to the powers and procedures set forth in the Agreement for arbitration the following shall apply:

(a) If by the terms of the Collective Bargaining Agreement a named individual, or his designee, is designated as the Arbitrator thereunder,

such named individual or his designee is hereby designated as the Arbitrator under this Supplemental Agreement.

(b) In the event the Collective Bargaining Agreement does not designate a named individual as the Arbitrator, then for the purpose of this Supplemental Agreement Jack Cerone, Esq., or his designee, is hereby designated Arbitrator.

(c) In the event of the death, disability or resignation of Jack Cerone, Esq. or his refusal to act as Arbitrator or to designate a substitute Arbitrator hereunder, then the successor Arbitrator shall be appointed forthwith by the Trustees.

(d) In the event of any breach or threatened breach of this Supplemental Agreement, the Arbitrator after a hearing may issue an award providing for a mandatory direction or prohibition, which award shall be final, conclusive, binding and enforceable in a court of competent jurisdiction.

(e) The parties consent that any papers, notices or processes, including subpoenas, necessary or appropriate to initiate or continue an arbitration hereunder or to enforce, confirm, vacate or modify an award may be served by certified mail directed to the last known address of the Employer, the Union and the Trustees.

(f) In the event a party to arbitration should default in appearing before the Arbitrator, the Arbitrator is hereby empowered to take the proof of the party or parties appearing and render an award thereon.

(g) The parties consent that an arbitration hearing may be called by giving five (5) days' notice by certified mail or two (2) days' notice by next day mail or other form of next day delivery to the other parties. However, the Arbitrator if he deems appropriate may call a hearing on shorter notice. The parties consent that arbitration hearings shall be heard at such places as the Arbitrator may designate.

(h) The Arbitrator shall have the authority, in such case as he shall deem proper, to order the Employer to pay all insurance and related claims to the extent of the schedule of benefits established from time to time by Trustees which arise during any period of suspension or cancellation of insurance coverage caused by nonpayment by the

Employer of the required contributions, and which claims remain unpaid because of said nonpayment.

(i) The Arbitrator shall have the authority, in such case as he shall deem proper, to include in his award against the Employer the reasonable costs of collection, including but not limited to the Arbitrator's fees, legal fees, auditing and accounting costs; providing, as well as liquidated damages, however, that no costs of collection shall be awarded against the Employer unless the said award shall also find that the Employer has failed to perform and comply with the terms and provisions of this Supplemental Agreement.

6. Employer shall furnish to Trustees, upon request, such information and reports as Trustees may reasonably require in the performance of their duties under the Trust Agreement. Trustees or any authorized agent or representative of Trustees shall have the right at all reasonable times during business hours to enter upon the premises of Employer and to examine and copy such of the books, records, papers and reports of Employer as may be reasonably required to permit Trustees to determine whether Employer is fully complying with the provisions of this Supplemental Agreement.

7. Trustees, in their own names as Trustees, may institute or intervene in any proceeding in law, equity or bankruptcy for the purpose of effectuating the collection of any sums due them hereunder from Employer.

8. No employee or member of an employee's family or any person claiming by, through or under any employee or member of an employee's family shall have:

(a) the right, privilege or option to receive, whether in lieu of the benefits referred to in paragraph 3 hereof or otherwise, any part of the sums payable hereunder by Employer to Trustees;

(b) any right, title or interest in or to or claim against any of the assets of Amalgamated Social Benefits Association except the right (subject to all conditions, provisions and rules relating thereto) to receive such of the said benefits as he or she may be or become entitled to; or

(c) the right, power or privilege to assign, transfer pledge or anticipate, or in any way create a lien upon, any of said benefits to which he or she may be or become entitled or to receive a cash consideration in lieu of such benefits, whether by the termination of Amalgamated Social Benefits Association, or through severance of the employee's employment, or otherwise.

9. In no event shall Employer be entitled to the return of any part of any sums paid hereunder by Employer to Trustees predecessors of the present Trustees, whether the Amalgamated Social Benefits Association has terminated or otherwise.

10. This Supplemental Agreement shall supersede all prior similar supplemental agreements relating to the Amalgamated Social Benefits Association entered into by and between Employer and Union, if any; provided, however, that neither the execution of this Supplemental Agreement nor any provision herein contained or contained in any other agreement shall be deemed to release Employer from the obligation and liability to make any payment to Trustees provided for in any such prior supplemental agreement or agreements and which became due and payable to Trustees prior to the effective date hereof and have not yet been paid to Trustees; and provided further that all sums paid by Employer to Trustees or to the predecessors of the present Trustees under any such prior supplemental agreement shall, to the extent that such sums have not been expended prior to the date hereof, be expended by Trustees for the purposes set forth in said prior supplemental agreement or agreements, subject to the terms and provisions of the Trust Agreement.

11. All the terms and provisions of the Trust Agreement are hereby expressly incorporated herein by reference. This Supplemental Agreement, the Collective Bargaining Agreement and the Trust Agreement shall be construed as a single document, and all the terms and provisions of the Collective Bargaining Agreement relating to administration and enforcement thereof (including provisions relating to arbitration) shall apply to the administration and enforcement of this Supplemental Agreement; provided, however, that in the event there should be a conflict between any provision of the Collective Bargaining Agreement and any provision of this Supplemental Agreement, the provision of this Supplemental Agreement shall be controlling.

12. The primary purpose of this Supplemental Agreement and the Trust Agreement being to provide a practical plan for providing the benefits referred to in paragraph 3 hereof, it is understood that the form of the plan of this Supplemental Agreement and of the Trust Agreement shall not give rise to a strict literal or formal interpretation or construction but such interpretation or construction shall rather be placed on this Supplemental Agreement and the Trust Agreement as will assist in the function of the plan for the benefit of employees and members of their families, regardless of form.

13. Regardless of the date on which this Supplemental Agreement is actually executed, it shall be effective as of the same date as the effective date of the Collective Bargaining Agreement, with the same force and effect as if it has been actually executed on that date. The provisions of this Supplemental Agreement shall remain in full force and effect for the full term of the Collective Bargaining Agreement and of any extensions

or renewals thereof, but shall terminate and come to an end with the Collective Bargaining Agreement or any extension or renewal thereof.

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Agreement to be executed by their duly authorized agents who have signed their names as of the day and year first above written.

OXXFORD CLOTHES, INC.

By: _____

Title: CFO

CHICAGO AND MIDWEST REGIONAL JOINT BOARD affiliated with Workers United/SEIU

By: _____

Title: Union Representative

Exhibit #II

SUPPLEMENTAL AGREEMENT

NATIONAL RETIREMENT FUND

This SUPPLEMENTAL AGREEMENT (the "Agreement") is made as of 10/1/2016, by and among **Oxxford Clothes XX, Inc., d/b/a Oxxford Clothes** (the "Employer"), **Chicago & Midwest Regional Joint Board**

(the "Union"), and the National Retirement Fund (the "Fund").

W I T N E S S E T H:

WHEREAS, the Employer and the Union have heretofore executed a collective bargaining agreement with respect to the Employer (the "Collective Bargaining Agreement");

WHEREAS, as part of the consideration for the execution, renewal and/or extension of the Collective Bargaining Agreement by the Union, the Employer agreed to contribute sums of money to the National Retirement Fund.

WHEREAS, as part of the consideration for the execution, renewal and/or extension of the Collective Bargaining Agreement by the Union, the Employer agreed to enter into a supplemental agreement in the form of this Agreement.

NOW, THEREFORE, in consideration of the covenants and conditions set forth herein, the parties agree that the Collective Bargaining Agreement shall be supplemented as follows:

1. Participation; Trust Agreement.

a. The Employer shall continue to participate in the National Retirement Fund (a "Participating Employer").

b. By participating in the Fund, the Employer shall be a party to the Agreement and Declaration of Trust of the National Retirement Fund, as amended (the "Trust Agreement"), which established the Fund as a jointly-administered Union-Management trust fund to provide benefits (in accordance with a written pension plan incorporated herein by reference) for employees of Participating Employers. To the extent the terms and conditions of this Agreement are inconsistent with the terms and conditions set forth in the Trust Agreement, the terms and conditions of the Trust Agreement shall control.

2. Contributions; Employee Participation.

a. Commencing as set forth in the current Collective Bargaining Agreement between the Union and the Employer, the Employer shall pay at the rate set forth in the Collective Bargaining Agreement, an amount per eligible employee who is a member of the bargaining unit covered by the Collective Bargaining Agreement (the "Contributions"). Such Contributions shall be submitted monthly, no later than the fifteenth (15th) day of the month following the month for which Contributions are to be made.

b. The Contributions shall be payable to the "National Retirement Fund" and shall be remitted to the office of the Fund.

b. Any controversy, claim, complaint, grievance or dispute relating to withdrawal liability may be submitted by the Fund (at the discretion of the Fund's Trustees or the Fund Administrator) or the Employer to final and binding arbitration in a proceeding in New York City, New York. Arbitration under this Paragraph 4(b) shall be conducted in accordance with the Multiemployer Pension Plan Arbitration (MEPPA) Rules for Withdrawal Liability Disputes of the American Arbitration Association.

c. The arbitrator's award in an arbitration under this Paragraph 4 shall be final and binding upon the parties hereto, and judgment upon the award may be entered in any court of competent jurisdiction in any state of the United States or country or application may be made to such court for a judicial acceptance of the award and an enforcement as the law of such jurisdiction may require or allow. Each party shall bear its own cost, including attorneys' fees, of the arbitration, except that if the Fund is the prevailing party in the arbitration, the arbitrator shall award the Fund all costs incurred by the Fund in such action in arbitration, including arbitration fees, auditors' fees, attorneys' fees and costs incurred by the Fund in the collection of the Employer's Contributions or other payments, interest at the rate of one percent (1%) per month or part thereof (or at such other rate as the Trustees may from time to time determine), and liquidated damages at an amount equal to the greater of interest on the delinquent Contributions or twenty percent (20%) of the delinquent Contributions. Nothing contained herein shall be deemed to prohibit the arbitrator from awarding interest to the prevailing party if the arbitrator deems it to be justified and appropriate.

IN WITNESS HEREOF, the parties hereto have caused this Supplemental Agreement to be executed by their duly authorized representatives as of the day and year first above written.

Oxxford Clothes XX, Inc., d/b/a Oxxford Clothes

By:
Title: CFO

Chicago & Midwest Regional Joint Board

By:
Title: union representative

National Retirement Fund
By: Alicare, Inc

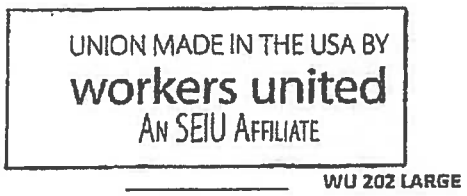
By: Richard N. Rust
Title: Fund Manager

Exhibit # 3

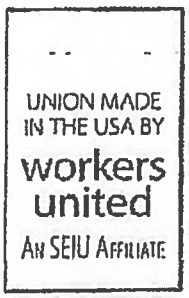
LICENSE AGREEMENT
EXHIBIT III

LICENSE AGREEMENT made as of October 1, 2016 by and between **CHICAGO & MIDWEST REGIONAL JOINT BOARD, WORKERS UNITED/SEIU** (herein called the "Licensor") and/or the international union of WORKERS UNITED, (herein called "WORKERS UNITED"), and the OXXFORD CLOTHES, INC. (herein called the "Licensee").

WHEREAS, WORKERS UNITED, a labor organization, has designed, adopted copyrighted and registered and is now the owner of labels for the identification of men's and boys' clothing which is the product of the labor of its members, a facsimile of which is as follows:



WU 202 LARGE



WU 201 SMALL

The foregoing labels are herein referred to severally as the "suit label", "garment label" and the "trouser label" and collectively as the "labels", and

WHEREAS, WORKERS UNITED has authorized the Licensor, if any, to enter into this License Agreement; and

WHEREAS, the Licensee, a manufacturer of men's and/or boys' clothing, is in contractual relations with the Licensor and/or WORKERS UNITED under a collective bargaining agreement in which the Licensee has agreed to affix copies of the labels to men's and boys' clothing manufactured by the Licensee to identify such clothing as the product of members of WORKERS UNITED and to meet the demand of the consuming public.

NOW, THEREFORE, the Licensor and/or WORKERS UNITED and the Licensee agree as follows:

1. The Licensor and/or WORKERS UNITED grants the Licensee a non-exclusive and non-assignable License to affix copies of the labels supplied by **ETHIX MERCH** to men's and boys' clothing manufactured by the Licensee only for its own use or the use of any other manufacturer licensed by the Licensor, WORKERS UNITED, or any of its affiliates; or, for the Licensee by contractors registered by the Licensee pursuant

to the provisions of the said collective bargaining agreement. The License shall not extend to any garments manufactured by the Licensee or by its registered contractors for any other manufacturer not licensed by the Licensor, WORKERS UNITED or any of its affiliates.

2. The Licensee shall affix copies of the labels to all appropriate garments manufactured by the Licensee or for the Licensee by registered contractors as follows.

a. a copy of the suit or garment label to every coat forming a part of a suit and to every sport coat, topcoat, and overcoat, and

b. a copy of the trouser label to every pair of single pants (but not to pants forming a part of a suit).

3. WORKERS UNITED reserves the right to substitute updated labels for the above referenced labels, should WORKERS UNITED's trademark registration change.

4. The Licensee shall cause all copies of labels supplied by the Union **thru ETHIX MERCH** to be sewed to the garments to which they are affixed by machine (and not by hand) during the process of construction. The Licensee shall not deliver any copies of the label or permit them to be delivered to any retailer or other person except as parts of the garments to which they have been affixed in the factory of the Licensee or the Licensee's contractors.

5. **Licensee will continue to purchase the union label designated by the union thru ETHIX MERCH** in such quantities as the production of the Licensee requires.

6. The Licensee shall not copy the labels, cause them to be copies, or obtain copies thereof except from WORKERS UNITED **thru ETHIX MERCH** pursuant to the provisions of this Agreement.

7. This License Agreement shall automatically terminate, without notice from WORKERS UNITED and the right of the Licensee to use the labels shall immediately cease in the event that:

a. the existing collective bargaining agreement between the parties terminates by lapse of time or otherwise and is not extended or renewed, with or without modifications; or

b. the General Officers of WORKERS UNITED determine that the Licensee has violated any of the terms or conditions of employment provided in the aforesaid collective bargaining agreement or the terms of this License Agreement. However, the right of the Licensee to use the label shall not be terminated until an opportunity is given to the Licensee to appear and be heard before the General Officers of WORKERS UNITED.

8. In addition to the label herein provided for, each garment sold by the Licensee bearing a size ticket shall have imprinted on the said size ticket a legend to the effect that the same is manufactured by WORKERS UNITED labor, or a facsimile of the Union Label. The exact copy to be printed on the size ticket shall be set by mutual agreement between the Clothing Manufacturers Association of the USA and the International Union. The text shall be the copyright of the CMA and the Union and may be used only so long as the Licensee shall have the right to use the labels pursuant to Paragraph 6 above.

9. In the event of the termination of this License Agreement, the Licensee shall forthwith deliver to WORKERS UNITED all copies of labels then in the Licensee's possession or control, and forthwith cease and desist from using size tickets bearing the legend provided for in Paragraph 8 above.

10. The exclusive right to institute legal proceedings for any unauthorized use of the labels shall remain in WORKERS UNITED, but WORKERS UNITED shall not be liable to the Licensee for any failure to institute such proceedings.

IN WITNESS THEREOF, the parties have hereunto set their hands and seals as of the day and year first above written.

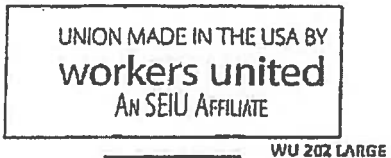
Chicago& Midwest Regional Joint Board
WORKERS UNITED/SEIU
Licensor
By: Mayrelo Ortiz, Union Representative

OXXFORD CLOTHES, INC.
Licensee
By: Steven [illegible], CFO

workers united

An SEIU Affiliate

UNION LABEL STOCK PROGRAM



WU 202 LARGE

WU 201 SMALL

qty	WU 201 SMALL TOT $	WU 201 SMALL ¢ / label	WU 202 LARGE TOT $	WU 202 LARGE ¢ / label
100,000	$1,200	1.2¢	$1,500	1.5¢
50,000	$650	1.3¢	$800	1.6¢
25,000	$350	1.4¢	$425	1.7¢
10,000	$200	2¢	$250	2.5¢
5,000	$150	3¢	$200	4¢
1,000	$70	7¢	$80	8¢

*All pricing in US dollars and includes free UPS ground shipping in the continental USA.

ETHIX MERCH

TO ORDER CALL: 877-709-3845

www.ethixmerch.com

sales@ethixmerch.com

NATIONAL RETIREMENT FUND

6 Blackstone Valley Place, Suite 302
Lincoln, RI 02865-1112

Phone: 401.334.4155
Fax: 401.334.5133

January 5, 2016

VIA FIRST CLASS MAIL

Oxxford Clothes XX, Inc.
Attn: Labor Relations
1220 W. Van Buren Street
Chicago, IL 60607

Chicago & Midwest Regional Joint Board
333 S. Ashland Avenue
Chicago, IL 60607

F40000001

Re: Minimum Required Contribution Rates for the Collective Bargaining Agreement (the "CBA") between Oxxford Clothes XX, Inc., d/b/a Oxxford Clothes and Chicago & Midwest Regional Joint Board.
ER#: 1001371
Duration of CBA: April 27, 2010 through April 26, 2013

To Whom It May Concern:

The above referenced CBA expired on 4/26/2013. In connection therewith, please consider this letter as notice of the minimum contribution rates that should appear in the renewal CBA in order to be acceptable per the National Retirement Fund's (the "NRF") requirements. Pursuant to the provisions of the new Adjustable Pension Plan that was adopted by the Trustees at their June 5, 2014 Board meeting the annual Rehabilitation Plan contribution rate increases effective with the 2015 increase for Oxxford Clothing XX will be increased by 4.56%. The annual contribution rate increases were previously based on 6.4%. The minimum contribution rates noted below were calculated using 4.56%.

NOTICE OF MINIMUM CONTRIBUTION RATES

For an acceptable renewal CBA, the following pension contribution rates, based on the adoption of the Preferred Schedule of the Rehabilitation Plan effective 6/1/2010 must be included in the renewal agreement:

Effective Date:	Rate Per Each Eligible Employee
6/1/2016	$0.63 per hour
6/1/2017	$0.65 per hour
6/1/2018	$0.68 per hour
6/1/2019	$0.72 per hour

8:30
4:30 pm

The language in the contract is acceptable as per the NRF's rules.

ADDITIONAL INFORMATION

Further, enclosed please find the following:

APPENDIX B

Your Health & Welfare Summary Plan Description

Amalgamated National Health Fund

Amalgamated Life

Gold Plus Plan

Amalgamated National Health Fund

Gold Plus Plan

333 Westchester Avenue
White Plains, New York 10604
(888) 771-9075

Board of Trustees

Noel Beasley	Lynne P. Fox	Homi Patel	Richard Rumelt
Patrick Cronin	Jean Hervey	Warren Pepicelli	Anthony Sapienza
David Eckwall	Julie Kelly	Harris Raynor	Steven E. Thomas
Richard Ellis	Desmond Massey	Edgar Romney	Cristina Vazquez
John Fowler	David Melman		

Agent for Service of Legal Process

Service of legal process may be made upon a Trustee or the Plan Administrator at:
333 Westchester Avenue, White Plains, NY 10604

Please note; additional trustee information is included on page 64.

Identification Number
27-4411485

Plan Sponsor Number
501

Type of Plan
Health & Welfare

Type of Plan Administration
All Coverage: Self-Insured

Plan Year
January 1 - December 31

A General Overview of the Plan in different languages is available upon request from the Fund Office.

Instructions for Spanish speaking participants:

Nota: En este folleto usted encontrará un resumen en inglés de su programa de derechos y beneficios bajo el Plan de Salud y Bienestar de Amalgamated National Health Fund. Si usted tuviera alguna dificultad en comprender alguna parte de este folleto, tenga a bien de ponerse en contacto con AliCare, Inc., Administrador del Plan para Amalgamated National Health Fund. 333 Westchester Avenue, White Plains, NY 10604. Horario de oficina: 8:30 a 4:15, de lunes a viernes. Teléfono: (888) 771-9075. Una revista general del Plan en Español esta a su disposición. Usted puede pedirlo de la oficina del Fondo.

Administered by AliCare, Inc.

Amalgamated Life, pursuant to a sub-contracting agreement with AliCare, Inc., provides certain administrative services to the Fund.

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3. Health Care Coverage (Continued)

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Major Medical Coverage
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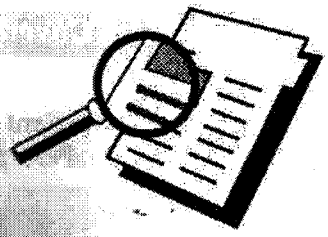
Your Plan At A Glance



Health Care Coverage

By using the Network of Hospitals, doctors and other health care providers, you will be entitled to maximum healthcare coverage for yourself and your family. The chart below summarizes your full managed care coverage and is included here as a "quick reference."

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used[1]
Annual Maximum	None.	None.
Annual Deductible	$250 per person, $500 per family.	$500 per person, $1,000 per family.
Out of Pocket Maximum	$6,350 per person, $12,700 per family.	Unlimited.
Hospital Coverage		
Hospital Inpatient Room, Board and Ancillary, Skilled Nursing or Acute Rehabilitation Facility, Birthing Center	100% of the network rate for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.	50% of reasonable billed charges for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.[2]
Hospice	100% of the network rate for up to a maximum period of six months and three bereavement counseling sessions per calendar year.	50% of reasonable billed charges for up to a maximum period of six months and three bereavement counseling sessions per calendar year.[2]
Hospital Outpatient		
Emergency Accident, Emergency Illness	80% of the network rate.	80% of reasonable billed charges.[2]

[1] For services where you have no control in selecting an in network provider (e.g. you used an in network provider but there were professional components that may have resulted in billing by non-network professionals such as an emergency room physician, anesthesiology, assistant surgeon, diagnostic interpretations such as radiology & pathology and ambulance) coverage will be paid at the in-network level of coinsurance based on usual and customary charges for the service provided.

[2] The reasonable billed charges are either the usual and customary charges for the service provided for network care or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Hospital Coverage (continued)		
Hospital Outpatient (continued)		
Non-emergency hospital, clinic, urgent care, or diagnostic only facility services	80% of the network rate. $25 co-payment per urgent care facility visit.	50% of reasonable billed charges.[1]
Ambulatory or Outpatient Surgery, Chemotherapy, Radio-therapy, and Pre-admission testing (within 7 days from admission)	80% of the network rate.	50% of reasonable billed charges.[1]
Major Medical Coverage		
Surgery Maternity, Assistant Surgeon, Second Surgical Opinion	80% of the network rate.	50% of reasonable billed charges.[1]
Organ Transplants	80% of the network rate.	Not covered.
Anesthesiology	80% of the network rate.	50% of reasonable billed charges.[1]
Physician Hospital Inpatient Visits	80% of the network rate.	50% of reasonable billed charges.[1]
Physician Office Visits	100% of the network rate, after a $15 primary care physician co-payment per visit and a $25 specialist co-payment per visit.	50% of reasonable billed charges.[1]
Home Health Care	80% of the network rate.	50% of reasonable billed charges.[1]
Diagnostic Imaging, X-Ray and Laboratory Testing (includes MRI, CT Scans, etc.)	80% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Therapeutic Professional Services (chemotherapy, radiation therapy, infusion therapy, dialysis, electroshock therapy)	80% of the network rate.	50% of reasonable billed charges.[1]
Physical Therapy	100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Speech Therapy	100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Occupational Therapy	100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Respiratory Therapy	80% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Cardiac Rehabilitation	80% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Allergy Testing and Treatment	80% of the network rate.	50% of reasonable billed charges.[1]
Injections/Immunizations	80% of the network rate (some immunizations may be covered at 100% of the network rate).	50% of reasonable billed charges.[1]
Accidental Injury To Sound Natural Teeth	80% of the network rate.	50% of reasonable billed charges.[1]
Durable Medical Equipment, Prosthetics, & Orthotics (includes medical supplies essential to DME, e.g. oxygen)	80% of the network rate. Shoe inserts are covered for up to a maximum payment of $500 every 2 years.	50% of reasonable billed charges.[1] Shoe inserts are covered for up to a maximum payment of $500 every 2 years.
Ambulance	80% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Blood	80% of the network rate.	50% of reasonable billed charges.[1]
Outpatient Psychotherapy	100% of the network rate, after a $25 co-payment per visit.	50% of reasonable billed charges.[1]
Outpatient Substance Abuse Therapy	100% of the network rate, after a $25 co-payment per visit.	50% of reasonable billed charges.[1]
Chiropractic Visits	100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Preventive Services	Certain preventive services are covered in full. Refer to page 31 for details. When a network provider is not used, preventive services are covered at 50% of reasonable billed charges.[1]	

Medical Certification Program — The Medical Certification Program requires that you call Alicare Medical Management at **1-800-332-5426** to obtain the Fund's certification before you or one of your covered dependents use any of the following services or procedures:

- If you are going into the hospital.
- If you are having any surgery.
- If you are having any high cost diagnostic or therapeutic treatment (over $500) such as Magnetic Resonance Imaging (MRI), CAT Scans, Dialysis or Infusion Therapy.
- If your doctor is planning to admit you to a skilled nursing facility, an acute rehabilitation facility or order home health care services.
- If you are going to have hospice care.
- If you are pregnant, you must call Alicare Medical Management if your physician or midwife has recommended a hospital length of stay for more than 48 hours following a normal vaginal delivery or more than 96 hours following a Caesarean Section. In addition, when you are in the hospital at the time of delivery, you must call Alicare Medical Management if it is determined that your stay will be longer than what is outlined above. Additional days that are not precertified may not be covered.
- If you are planning to participate in an approved experimental and/or clinical trial with respect to the treatment of cancer or another life-threatening disease or condition.

If you do not notify Alicare Medical Management when required, your claims for those services will not be covered, or will not be covered in full. The toll free telephone number to call Alicare Medical Management is **1-800-332-5426.**

The 24-Hour Nurse HelpLine

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support and counseling. In addition to speaking with a nurse, callers may choose to listen to any of over 1000 pre-recorded tapes dealing with a wide range of medical topics such as allergies, diet, children's health and development, HIV/AIDS, cancer, exercise, dental health, drug abuse, and many other topics. Close to 600 of these tapes are also available in Spanish. Call the Nurse HelpLine at **1-800-557-6796**.

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Prescription Drug Coverage

Covered through a card program for up to a 34 day supply, after a $15 co-payment for generic drugs, a $30 co-payment for formulary brand name drugs, and a $45 co-payment for non-formulary brand name drugs.

Also covered through a maintenance mail order program for up to a 90 day supply after a $30 co-payment for generic drugs, and a $60 co-payment for formulary brand name drugs, and an $90 co-payment for non-formulary brand name drugs.

Vision Care Coverage

Covered up to $200 per person each 24 months for eyeglasses or contact lenses and/or an eye examination.

Affordable Care Act

The benefits summarized in this Summary Plan Description are intended to comply with the Patient Protection and Affordable Care Act (the Affordable Care Act). Any further modifications required by the Affordable Care Act will be made as necessary at the appropriate time.

2. Basic Information

What Is The Health And Welfare Plan?

The security of your family is an important concern to your employer and your Union. Without adequate protection, the cost of an illness or injury could become a serious financial burden.

Naturally, the hope is that serious illness or injury never comes your way. However, with benefits available through the Health and Welfare Plan of the Amalgamated National Health Fund, you can be assured that you and your family have the protection you need through a wide range of coverage.

The Plan described in this booklet is effective for participants of the Fund who are covered by collective bargaining agreements which provide for the appropriate contributions for this coverage.

The Plan is administered by the Board of Trustees (the "Trustees") of the Amalgamated National Fund (the "Fund"). No individual or entity, other than the Trustees (including any duly authorized designee thereof) has any authority to interpret the provisions of the Plan or to make any promises to you about the Plan.

The Trustees (including any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plan (and any related Plan documents) including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plan. These decisions shall be final and binding upon all parties affected by such decisions.

How To Use This Booklet

This booklet is your primary source of information on the Plan. You cannot rely on information from co-workers, union or employer representatives. If you have any questions about the Plan and how its coverage works, the Fund staff will be glad to help you. Since telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan document.

This booklet is called a Summary Plan Description. It is designed to help you understand how your Health and Welfare Plan works. Because certain parts of the Plan are complicated, every effort has been made to present this material in a way that is easy to understand.

To assist you in understanding your coverage, there are overview and summary charts throughout the booklet. However, it is important for you to read the entire booklet to fully understand what you are entitled to, so that you can make the best use of your Plan coverage.

If there are any special provisions that apply to you because, for example, you work in a particular state, you will receive a special note describing such provisions.

If after reading this booklet you have any questions about the Plan and how its coverage works, the Fund Office will be glad to help you.

Who Pays The Cost Of The Plan?

The Plan is provided as part of the Collective Bargaining Agreement between the Union and your employer. As a participant in the Plan, you may be required to pay a part of the cost of your health care coverage. You may also be responsible for premium payments on behalf of your dependents. The part of the health care coverage that you pay for may be paid on a tax-free basis.

Who Is Covered?

You:

When you meet the Plan's requirements for coverage (see next section), you are covered for:

- health care
- prescription drugs
- vision care

Your Dependents:

Your covered dependents are:

- your spouse, which means an individual whose marriage was validly entered into in a jurisdiction whose laws authorize such marriage regardless of where such individual currently resides; and
- your natural children from birth to the end of the month for which the child turns 26, your adoptive children from when they are placed with you for adoption to the end of the month for which the child turns 26, your unmarried stepchildren to the day they become age 19, if they are living with you. Eligible stepchildren between the ages of 19 and 26 are not required to be living with a parent(s). Children under legal guardianship until the end of the month for which the child turns 26, unless health care coverage is available through a dependent child's employer; and
- your unmarried dependent children age 26 and older who are incapable of self-sustaining employment due to mental illness, developmental disability, physical handicap or mental retardation, if the condition began prior to age 26 and the child has been continuously covered for Fund benefits prior to age 26.[1]

Dependent Open Enrollment Period

There will be an annual one-month open enrollment period during which time employees may upgrade their coverage from single to family coverage. The annual open enrollment will be during the month of November of every year and coverage for newly added dependents will commence on January 1st of the following year. The only exception is for newly hired employees or for employees whose status has changed due to marriage and the birth, adoption or legal guardianship of a child. Employees will have 31 days after the event to change from single to family coverage. Employees must supply proof, such as a marriage license, birth certificate or an adoption decree from a court of law.

In addition, effective April 1, 2009, you and your dependents may also enroll in this Plan if you (or your dependents):

- have coverage through Medicaid or a state Children's Health Insurance Program ("CHIP") and you (or your dependents) lose eligibility for that coverage; or
- become eligible for a premium assistance program through Medicaid or CHIP.

[1] The Fund Office must be notified of any handicapped dependent children when they become age 26 and a medical form must be completed by a physician certifying that the handicap results in total disability and in complete financial dependence on the participant. Periodic updating of the medical condition will be required and the Fund may require that the dependent be examined by Fund physicians.

Qualified Medical Child Support Orders:

The Plan will provide health care coverage in accordance with a Qualified Medical Child Support Order, which is any judgment, decree or order issued by a court which recognizes a child or children's right to receive benefits under a group health plan in which the child's parent is an eligible participant.

The Qualified Medical Child Support Order must specify: the name and last known mailing address of the participant and the name and address of each of the eligible children, a description of the type of coverage to be provided, the period to which the order applies, and each plan to which the order applies.

The Qualified Medical Child Support Order can not require the Plan to provide any benefit or option not otherwise provided under the Plan.

When a Qualified Medical Child Support Order is received by the Plan, its receipt will be acknowledged and you will be advised of the Plan's determination of whether the court order is a Qualified Medical Child Support Order. If you would like to receive a copy of the Plan's procedures with respect to Qualified Medical Child Support Orders, please write to the Plan Administrator and a copy will be sent to you free of charge.

When Coverage Begins

When you are actively working for a contributing employer either full or part-time and you and your employer are making payments to the Fund on your behalf, you are considered to be working in **covered employment,** and therefore eligible for coverage under the plan.

If you are on the payroll and actively employed by a contributing employer on the date this coverage first goes into effect, your and your dependents Plan coverage begins on that date. If you are hired on or after the effective date, your healthcare coverage begins on the first day of the month for which contributions are received on your behalf, but in no case later than the first of the month following 60 days from your date of hire.

A signed and completed enrollment form must also be submitted to the Fund within 30 days from your date of hire, including any additional documents that may be required for dependent coverage (i.e. birth certificate, marriage license), in order for coverage to begin.

When Coverage Ends

If you employer fails to make its required contributions to the Fund and is delinquent, the Trustees of the Fund may terminate your coverage.

All coverage ends on the last day of the month for which premiums are received. You and your dependents may have the right to a temporary extension of your health care coverage under the federal COBRA law.

Some collective bargaining agreements may have different extensions which will be communicated separately to those affected. Please consult your union representative or the Fund office for more information.

Out-of-Pocket Maximum

WHEN A NETWORK PROVIDER IS USED:

If your out-of pocket costs for coinsurance, deductible and co-payments for covered health care expenses exceed $6,350 per person or $12,700 per family in any calendar year, the Plan will then pay 100% of the network rate for covered Health Care charges for the remainder of that calendar year.

WHEN A NETWORK PROVIDER IS NOT USED:[1]

There is no out-of-pocket maximum for covered health care expenses if an out-of-network provider is used.

Family Medical Leave Act (FMLA)

If you apply for and are eligible for FMLA, coverage and contributions are required to continue through the end of the month following 84 days (12 weeks) from your separation of employment.

Reinstatement Of Coverage

If you are on layoff, disability, leave of absence or FMLA and return to work within twelve (12) months after leaving covered employment, coverage will be reinstated on the first of the month following your return to employment. If you return to work within twelve (12) calendar months after losing coverage, you cannot change coverage levels until open enrollment. If you have had a change of family status during the leave, you must complete a new enrollment form.

If you are on layoff, disability, leave of absence or FMLA and return to work twelve (12) or more calendar months after leaving employment, you will be treated like a new employee and coverage will begin on the first of the month following sixty (60) calendar days of your return to work date and you must complete a new enrollment form.

[1] For services where you have no control in selecting an in network provider (e.g. you used an in network provider but there were professional components that may have resulted in billing by non-network professionals such as an emergency room physician, anesthesiology, assistant surgeon, diagnostic interpretations such as radiology & pathology and ambulance) coverage will be provided at the in-network level of coinsurance based on usual and customary charges for the service provided.

3. Health Care Coverage

Introduction

The Amalgamated National Health Fund is pleased to provide you with improved coverage under your health and welfare Plan through a managed care program in conjunction with a Preferred Provider Organization.

This Preferred Provider Organization (PPO) has been chosen by the Amalgamated National Health Fund for its excellent reputation in delivering high quality health care, while limiting your out-of-pocket medical expenses. No provider is an employee of the PPO. Each is in private practice or is associated with a health facility.

You can visit your network provider's website for a list of the names, addresses and phone numbers of hospitals, physicians and other providers in the network. **However, you should review the coverage described in this booklet to be sure that benefits are provided by your Plan for the services you select.** These providers all meet the high standards of quality generally accepted in the medical community and will be available to care for you and your family whenever you need medical assistance. When you go to one of the covered providers in the Network, your benefits will be substantially improved.

Call the phone number on your ID Card if you have questions about your eligibility.

Questions about the Network or about claims issues with Network doctors should be directed to the Managed Care HelpLine at **1-800-248-3666.**

Controlling Health Care Costs

Everyone is aware that health care costs have been rising very sharply. The Fund has introduced many new comprehensive programs to help protect you and your family against these costs. However, as consumers, we are all burdened with these costs and their impact on the nation's economy, even when we are protected by health care coverage.

One of the factors that has led to such high costs is the inefficient use of health care. You can help to control this situation by becoming a wise consumer of health care. With your help, the Fund can continue to keep coverage levels high and your out-of-pocket expenses low.

Here are some of the ways you can help:

- Receive your medical care from in-network doctors. This keeps health care costs low and your coverage high.
- Avoid using the emergency room unless it is a true medical emergency[1]. Consider using an urgent care center or your primary care physician instead. Call the Nurse HelpLine to see if a true medical emergency exists.
- If you need surgery ask your doctor if the surgery can be performed without a hospital inpatient admission, in an ambulatory surgical center, in the hospital outpatient department or in the doctor's office. It may be safer, quicker and more comfortable for you.
- Do not have diagnostic testing performed at a hospital outpatient facility if possible. It is typically far more expensive and you are likely to have higher out-of-pocket expenses.
- Be sure to leave the hospital as soon as your doctor thinks it is medically appropriate.
- Ask your doctor if a hospital stay can be shortened by using a skilled nursing or acute rehabilitation facility, or home health care.
- Consider using alternatives to hospital inpatient coverage such as a birthing center or a hospice program when medically appropriate.
- When you leave the hospital, ask for a copy of the bill. If you find an error in the bill and the Fund is able to recover any overpayment, you may be eligible to receive 20% of the recovered amount.

[1] A true emergency is the sudden and unexpected onset of a serious condition or illness for which treatment cannot be delayed without the risk of losing your life or seriously or permanently impairing your health. For example, if you go to the emergency room as a result of cardiac pain, massive bleeding, poisoning, shock, severe or multiple injuries of a stroke, treatment will be covered.

The 24 Hour Nurse HelpLine

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll-free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support and counseling. In addition to speaking with a nurse, callers may choose to listen to any of over 1000 pre-recorded tapes dealing with a wide range of medical topics such as allergies, diet, children's health and development, HIV/AIDS, cancer, exercise, dental health, drug abuse, and many other topics. Close to 600 of these tapes are also available in Spanish. Call the Nurse HelpLine at **1-800-557-6796**.

Getting Well, Staying Well Program

Your good health and the good health of your family is one of the most important things you can have. Your health Fund provides many benefits that help you cover costs when you are sick, but also wants to help you get well and stay well. Chronic diseases like heart disease, diabetes, back pain, asthma and cancer are often preventable. If you are already affected by a chronic disease, it may be possible to manage it better to improve your quality of life.

The Getting Well, Staying Well Program can help you live healthier and feel better. It can help you learn more about treating your existing health conditions and preventing new ones from developing. The program will provide you with a registered nurse who will be your personal health coach. He or she will be your partner to develop a customized program just for you. It's completely up to you to decide if working with a personal health coach can make a difference in your life. **The program services are completely confidential and is free to you.**

To participate in the program you will need to complete a simple Health Risk Assessment. It is simple and quick to complete. You can take the Health Risk Assessment online at http://www.Alicaremed.com. Click on "Member Resources" then "Health Risk Assessment" then "New Members Register Here." When the system asks you to enter a company name, enter **FUND**. Create your own user name and password to use as your personal account from then on. You can also set up an appointment to do the Health Risk Assessment on the phone by calling **1-866-663-7486**.

Remember, it's free and confidential and it can help you live a longer and healthier life.

Medical Certification Program

Medical Certification Program:

You and your covered dependents must call first to assure payment:

- *If you are going into the hospital*
- *If you are having any surgery*
- *If you are having an MRI, CAT Scan, Dialysis or Infusion Therapy*
- *If you are pregnant*
- *If your maternity stay in the hospital exceeds 48 hours following a normal vaginal delivery or 96 hours following a Cesarean Section*
- *If skilled nursing facility or home health care services are ordered by your physician*
- *If you are going to have hospice care*

Call Alicare Medical Management at:
1-800-332-5426

The Medical Certification Program is a cooperative effort in which the Fund's medical professionals work with you, your family, your doctor and hospital to assure you of the highest quality care and to help eliminate unnecessary surgeries, unnecessary days in the hospital, and other unnecessary medical treatment.

The Medical Certification Program requires that you and your covered dependents call Alicare Medical Management in the following situations:

- If you are going into the hospital, as soon as your admission date has been scheduled
- If your doctor is planning any surgery, whether or not a hospitalization is planned
- If you are having any high cost diagnostic or therapeutic treatment (over $500) such as Magnetic Resonance Imaging (MRI), CAT Scans, Dialysis or Infusion Therapy
- If you are pregnant, you must call Alicare Medical Management when you know you are pregnant. You must also call again if your physician or midwife has recommended a hospital length of stay for more than 48 hours following a normal vaginal delivery or more than 96 hours following a Cesarean Section. The Fund may not cover additional days that are not precertified.

  In addition, when you are in the hospital at the time of delivery, you must call Alicare Medical Management if it is determined that your stay will be longer than what is outlined above. The Fund may not cover additional days that are not precertified.
- If your doctor is planning to admit you to a skilled nursing facility, an acute rehabilitation facility or order home health care services
- If you are going to have hospice care

If Alicare Medical Management determines that a second opinion is necessary, the medical reviewer will arrange an appointment for you with a local doctor who is a certified specialist or surgeon. The appointment will be made at a time and place most convenient for you. The Plan pays for the full cost of the second opinion including the doctor's fee and any tests.

The doctor providing the second opinion will be told to bill the Fund directly so you should never even receive a bill. If the doctor does not confirm the need for surgery, you may request a third opinion. The Plan will also pay for a third opinion if requested.

The Fund's doctors and/or nurses will contact your doctor and your hospital to provide a professional review of your treatment and determine that the care you receive is medically necessary and delivered in the appropriate setting for your treatment.

If Alicare Medical Management determines that your proposed treatment is not medically necessary, you and your doctor will be advised. If you go ahead with treatment that Alicare Medical Management determines is unnecessary or is in an inappropriate setting, the Plan will not cover the costs for that part of your care.

Failure to comply with the Fund's Medical Certification Program will result in the Plan's denial of benefits. You may resubmit your claim for payment once you receive the appropriate post-review certification.

A separate brochure containing full details of this program is available from the Fund Office or your Joint Board or Local Office. The toll free telephone number to call Alicare Medical Management is **1-800-332-5426.**

PLEASE NOTE:

- **To obtain the required approval of the Plan for any of the above services, you must call Alicare Medical Management at 1-800-332-5426.**
- **You must also call the phone number on your hospital identification card to confirm your eligibility and overall benefit availability. Medical certification alone does not guarantee eligibility or benefit availability.**

Medical Case Management

Medical Case Management is a service provided to you and your family when experiencing catastrophic medical situations. You will be contacted by the Fund's Registered Nurses, located around the country, who work directly with you, your family, the hospitals and physicians to help manage the medical care of the patient. They can help make arrangements with providers and enable you and your family to explore all potential health care options and alternatives. The program's services are free to those patients eligible for Fund Coverage.

How The Network Works

Network providers have agreed to accept the Fund's payment as payment in full, after you pay your coinsurance. Therefore, if you or your covered dependents use a Network provider, your only cost for covered health care charges will be for the coinsurance, where applicable.

If you have any questions about your claims with Network doctors, please call the Managed Care HelpLine at **1-800-248-3666.**

Using The Network

When you call to make an appointment with your doctor or other health care provider, be sure to identify yourself as an Amalgamated National Health Fund participant and give the name of your network provider. Bring your health benefit plan identification card with you each time you visit the provider. For your first visit, bring:

- notes about your family and personal medical history
- a list of all medications you are taking
- a list of your past hospitalizations, if any, and the dates of those visits
- your immunization records
- a record of your last tuberculin skin test.

Be prepared to discuss your current medical problem or condition.

When any referral is made, remind your doctor that you prefer to go to a network provider, if possible.

If you have any questions about finding a Network provider, please call your Preferred Provider Organization (PPO) at the number on your health benefit plan identification card.

Finding A Network Provider

Check your Network provider's website for a list of Network hospitals and/or individual Network providers.

Physicians may be nominated for the network. To have your physician considered for the network, please request a Physician Nomination Form from your network provider.

Hospital Inpatient Coverage

SUMMARY

Up to 120 days per calendar year.

Hospital Inpatient Coverage For:

- *Semi-private room and board*
- *Intensive Care Unit*
- *Coronary Care Unit*
- *Medically necessary private room*
- *Hospital billed ancillary services and supplies*
- *Birthing Center*
- *Skilled Nursing or Acute Rehabilitation Facility*
- *Hospice*

All hospital admissions are subject to the Medical Certification Program.

All Fund participants and their covered dependents who are going into the hospital must notify Alicare Medical Management as soon as the admission date has been scheduled. If you are unable to call within 48 hours, call as soon as possible after the admission. Failure to call will result in a reduction of coverage.

For services where you have no control in selecting an in network provider (e.g. you used an in network provider but there were professional components that may have resulted in billing by non-network professionals such as an emergency room physician, anesthesiology, assistant surgeon, diagnostic interpretations such as radiology & pathology and ambulance) coverage will be provided at the in-network level. If, under these circumstance, coverage is not provided at the in-network level automatically during claims payment, please send a letter to or call Customer Service at **1-888-771-9075** and explain the circumstances.

Hospital inpatient facilities and hospital billed services and supplies are covered for up to 120 days per calendar year. Coverage is provided for:

- semi-private room and board
- the intensive care unit (ICU), coronary care unit (CCU), and a certified medically necessary private room
- ancillary services and supplies billed by the hospital, including:
  - laboratory tests
  - X-rays
  - use of operating and recovery rooms
  - use of equipment for blood transfusions
  - most other services and supplies a hospital normally provides for its patients
- birthing center
- skilled nursing or acute rehabilitation facility
- hospice
- mental health conditions
- substance abuse admissions

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 100% of the network rate, subject to the $250 per person, $500 per family, calendar year deductible.
- **If you do *not* use a Network facility:** Covered at 50% of reasonable billed charges[1], subject to the $500 per person, $1,000 per family, calendar year deductible.

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Some of the above services may be performed by professionals who are not employees of the hospital and who may bill the patient separately, that is, the charges will not be part of the hospital bill. When this happens, these charges may be covered under your Major Medical Coverage.

The following limits to hospital inpatient coverage apply:

- For purposes of the 120 days during any calendar year, successive confinements where there is not a legitimate discharge of at least 24 hours are considered continuous confinements and subject to the 120 day maximum or the calendar year maximum, whichever occurs first. This also applies to confinements that cross over into a new year. Confinements not separated by a legitimate return to work or by return to some other type of normal activity, may also be considered one confinement. In any event, if multiple confinements are deemed to be separated solely to circumvent this limitation, they will be considered one confinement for the purposes of this rule.
- Charges for a private room that is not certified as medically necessary will be covered up to the hospital's average semi-private room rate or, if the hospital has no semi-private room rate, the average semi-private room rate for that area.

Mental Health and Substance Abuse

A mental health condition means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin.

Substance abuse means the taking of alcohol and/or drugs in amounts that place a person at risk.

Hospital Bill Auditing

It is the policy of AliCare, Inc., to audit hospital bills in order to assure that proper billing practices are observed by the hospital, and that only medically necessary procedures are billed for.

Regardless of the outcome of any audit, you will not be responsible for any outstanding charges except for those charges, such as personal convenience items, experimental procedures, deductibles, co-payments, precertification penalties, or any other expenses not covered by the Fund.

Hospital Bill Auditing Incentive Program

You can help the Fund in its hospital bill auditing efforts.

Hospitals frequently make mistakes in their billing. Sometimes they bill for services and supplies that are never provided or for more days than the patient is hospitalized.

When you are discharged from the hospital, request a copy of the itemized hospital bill. You are entitled to receive the itemized bill, and there should be no charge. Then, review the bill very carefully. Be certain that all the services and supplies listed on the bill were received and that the number of days indicated on the bill is correct.

If you find an overcharge on your hospital inpatient bill, and if the Fund is able to recover any of its overpayment, the Fund will pay you 20% of the recovered amount.

Skilled Nursing or Acute Rehabilitation Facilities

A skilled nursing or acute rehabilitation facility is a specially licensed institution (or part of an institution such as a hospital) which allows patients to recover in an environment devoted to rehabilitation. A skilled nursing or acute rehabilitation facility is appropriate for patients who need specialized care on a daily basis, but no longer need to be confined to a hospital. Arrangements, including pre-certification, must be made through Alicare Medical Management.

Coverage is provided for short-term rehabilitation during the acute stages of an illness or injury when a physician has determined that therapy will result in a significant improvement in the acute condition within a specified time period.

Confinements for rehabilitation and rehabilitation services billed by the facility, such as speech, occupational and physical therapy, and cardiac/pulmonary rehabilitation, are limited to those services provided to correct an impairment due to accident or sickness, or a congenital defect for which corrective surgery has been performed.

The Plan covers the reasonable charges of a skilled nursing or an acute rehabilitation facility providing all the following conditions are met:

- the patient was transferred to the skilled nursing or acute rehabilitation facility for treatment of the same condition that was treated in the hospital, and
- the patient's doctor must certify that the patient requires daily skilled nursing or acute rehabilitation care, and that the patient's doctor supports the medical necessity of that care.

When these conditions are met, the charges of a skilled nursing or acute rehabilitation facility are covered instead of and to the same extent as each day of the unused days of hospital inpatient coverage (see "Hospital Inpatient Coverage")

Hospices

A hospice is a facility or program of care designed to meet the special needs of terminally ill patients and their families. Hospice services are usually provided at home, but inpatient care is available where necessary. Hospice care must be precertified and arranged by Alicare Medical Management.

While hospice coverage is provided, no other Plan health care coverage is available to that patient. The Plan covers the charges for the following services and supplies provided by a hospice:

- hospital inpatient care
- professional nursing visits (not full-time care)
- home health aide visits
- physical therapy
- occupational therapy
- respiratory therapy and equipment
- physician visits
- lab tests and X-rays
- chemotherapy/radiation therapy for symptom control
- prescription drugs
- rental of medical equipment
- medical/surgical supplies
- ambulance.

Hospice care is limited to a maximum period of six months and three bereavement counseling sessions per calendar year.

Hospital Outpatient Coverage

SUMMARY

Coverage Provided for:

- *Surgery*
- *Chemotherapy*
- *Radiation Therapy*
- *Emergency Treatment*

Hospital Outpatient Coverage

The Plan covers charges, services, and supplies billed by the hospital. Coverage is provided for the following services:

- non-emergency hospital, clinic, urgent care, or diagnostic only facility services
- ambulatory or outpatient surgery
- chemotherapy
- radiation therapy.

Professional fees which are not billed by the hospital (that is, charges that do not appear on the hospital bill), are not covered under Hospital Outpatient Coverage.

Non-emergency coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 80% of the network rate, subject to the $250 per person, $500 per family, calendar year deductible. $25 co-payment per urgent care facility visit.
- **If you do *not* use a Network facility:** Covered at 50% of reasonable billed charges[1], subject to the $500 per person, $1,000 per family, calendar year deductible.

Hospital Outpatient Emergency Room Treatment

The Plan covers the cost of Outpatient Emergency Room treatment, for a true emergency illness or accident only[2].

Coverage is provided on the following basis:

- **If you use a Network facility:** Covered at 80% of the network rate, after a $100 co-payment per visit, within 48 hours of a true emergency only.[2]
- **If you do *not* use a Network facility:** Covered at 80% of reasonable billed charges[1], after a $100 co-payment per visit, within 48 hours of a true emergency only.[2]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

[2] A true emergency is the sudden and unexpected onset of a serious condition or illness for which treatment cannot be delayed without the risk of losing your life or seriously or permanently impairing your health. For example, if you go to the emergency room as a result of cardiac pain, massive bleeding, poisoning, shock, severe or multiple injuries of a stroke, treatment will be covered.

Major Medical Coverage

SUMMARY

Major Medical Coverage for:

- *surgery*
- *assistant surgeon*
- *organ transplant*
- *anesthesiology*
- *physician charges (see limits)*
- *diagnostic imaging, x-ray and lab testing*
- *therapeutic professional services*
- *home health care*
- *physical therapy (see limits)*
- *speech therapy (see limits)*
- *occupational therapy (see limits)*
- *respiratory therapy (see limits)*
- *cardiac rehabilitation (see limits)*
- *allergy testing and treatment*
- *accidental injury to natural teeth*
- *injections/immunizations*
- *durable medical equipment and devices*
- *ambulance*
- *blood (if not replaced)*
- *outpatient psychotherapy*
- *outpatient substance abuse therapy*
- *chiropractic care (see limits)*
- *preventive services*

Coverage for **Surgery, Maternity,** the services of an **Assistant Surgeon, Second Surgical Opinion,** is provided on the following basis:

- **If you use a Network facility:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network facility:** Covered at 50% of reasonable billed charges[1], subject to the deductible.

Surgery

If any surgery is planned for you or your covered dependents, whether or not a hospitalization is planned, you must notify Alicare Medical Management. Failure to call will result in a reduction in coverage (see "Medical Certification Program").

In addition, the Plan provides coverage for breast reconstruction in connection with a mastectomy. Breast reconstruction may be selected in a manner determined by you or a covered dependent in consultation with your attending physicians, and the plan will provide benefits as follows:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Assistant Surgeon

The Plan also provides coverage for the charges of an assistant surgeon when it is determined to be medically necessary, according to a fixed schedule of charges for assistant surgery. This benefit is paid only to a licensed Physician or a Physicians Assistant.

Organ Transplant Coverage

Requests for coverage for an organ transplant must be submitted to Alicare Medical Management in writing to obtain prior authorization. Authorized transplants will be covered, subject to the limits of the Plan's coverage. If you do ***not*** use a network provider, Organ Transplant Coverage is not covered.

The following items and services are also specifically excluded:

- Services provided not in accordance with prior authorization
- Procurement of the organ for transplant, including charges for the preparation and transportation of the organ for transplant
- An organ that is synthetic, artificial or obtained from other than a human body
- An organ procurement or organ transplant performed outside the

continental United States

- Prescription drugs, including immunosuppressant drugs, not billed by the hospital during an inpatient confinement, unless available through the Fund's Prescription Drug Program
- Transplants deemed to be experimental or not medically or clinically appropriate as determined by the Fund's Medical Director, generally accepted standards of medical practice, or in accordance with government guidelines.

When both the recipient and the live donor are covered persons under the Plan, both are entitled to these benefits. When only the recipient is a covered person, both the live donor and the recipient are entitled to the benefits, but the live donor's benefits are limited to those not provided or available to the live donor from any other source. In both cases, benefits provided to the live donor will be charged against the recipient's coverage. When only the live donor is a covered person, only the live donor is entitled to benefits, but benefits are limited to those not provided or available to the live donor from any other source.

Transplant Centers — Coverage for organ and/or bone marrow transplants, which have been authorized by Alicare Medical Management, are covered only in a Transplant Center that has been approved by the Fund. These facilities are approved by the Fund based on quality of care and cost effectiveness. Transportation for the patient to an approved Center may be included in the program's coverage. All arrangements will be made through Alicare Medical Management.

Anesthesiology

Major Medical Coverage covers the charges of a legally licensed anesthesiologist as follows:

- **If you use a Network provider:** Covered at 50% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges[1], subject to the deductible.

[1]The reasonable billed charges are either the usual and customary charges for the area involved, the network rate, or the Fund's schedule.

Physician Charges

Major Medical Coverage covers the charges of a legally licensed doctor of medicine, doctor of osteopathy, doctor of podiatry and a naturopathic doctor as follows:

Physician Visits (Non-Surgical) While In The Hospital

- **If you use a Network provider:** Covered at 80% of the network rate, for up to 120 visits per calendar year, based on the number of certified hospital inpatient days, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges for up to 120 visits per calendar year, based on the number of certified hospital inpatient days, subject to the deductible.[1]

Physician Office Visits

- **If you use a Network provider:** Covered at 100% of the network rate, after a $15 primary care physician co-payment per visit and a $25 specialist co-payment per visit.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the the deductible.[1]

Physician charges for surgery are covered under Surgical Coverage.

Diagnostic Imaging, X-Ray, and Laboratory Testing

Major Medical Coverage provides for the following diagnostic x-ray and laboratory services:

- Diagnostic tests
- Interpretations
- CAT Scan
- MRI
- MRA
- Nerve conduction studies
- Ultrasounds
- Amniocentesis
- Visual field tests
- Mammography

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.

Therapeutic Professional Services

Major Medical Coverage provides coverage for the following therapeutic professional services:

- Chemotherapy
- Radiation Therapy
- Infusion Therapy

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

- Dialysis
- Electroshock Therapy

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Home Health Care

Major Medical Coverage covers charges for home health care as follows:

- **If you use a Network facility:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network facility:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Physical Therapy

Major Medical Coverage covers charges for physical therapy as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

Speech Therapy

Major Medical Coverage covers charges for speech therapy as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

Occupational Therapy

Major Medical Coverage covers charges for occupational therapy as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment, for up to 30 visits per calendar year.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

Respiratory Therapy

Major Medical Coverage covers charges for respiratory therapy as follows:

- **If you use a Network provider:** Covered at 80% of the network rate for up to 30 visits per calendar year, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

[1]The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Cardiac Rehabilitation

Major Medical Coverage covers charges for cardiac rehabilitation as follows:

- **If you use a Network provider:** Covered at 80% of the network rate for up to 30 visits per calendar year, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

Allergy Testing and Treatment

Major Medical Coverage covers charges for allergy testing and treatment as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Accidental Injury To Natural Teeth

Major Medical Coverage covers charges for accidental injury to natural teeth within one year of injury as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Injections/Immunizations

Major Medical Coverage covers charges for injections/immunizations as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible (some immunizations may be covered at 100% of the network rate).
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Durable Medical Equipment, Prosthetics & Orthotics

Major Medical Coverage covers the purchase or rental of medically necessary durable medical equipment, prosthetic devices and orthotics. This includes medical supplies essential to DME, e.g. oxygen. Coverage is provided as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible. Shoe inserts are covered for up to a maximum payment of $500 every two years.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1] Shoe inserts are covered for up to a maximum payment of $500 every two years.

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Ambulance Services (includes Air Ambulance)

Major Medical Coverage provides coverage for medically necessary transportation by ambulance, including air ambulance, as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Blood

Major Medical Coverage provides coverage for blood as follows:

- **If you use a Network provider:** Covered at 80% of the network rate, subject to the deductible.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.[1]

Outpatient Substance Abuse Therapy

Major Medical Coverage provides coverage for outpatient substance abuse therapy as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment per visit.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.

Full confidentiality of all records regarding these claims is assured.

Outpatient Psychotherapy

Major Medical Coverage provides coverage for outpatient psychotherapy as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment per visit.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, subject to the deductible.

Full confidentiality of all records regarding these claims is assured.

Chiropractic Care

Major Medical Coverage covers charges for chiropractic care as follows:

- **If you use a Network provider:** Covered at 100% of the network rate, after a $25 co-payment per visit, for up to 30 visits per calendar year.
- **If you do *not* use a Network provider:** Covered at 50% of reasonable billed charges, for up to 30 visits per calendar year, subject to the deductible.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Preventive Services

The following is the list of preventive services that are covered in full if you use a network provider. **If you do *not* use a network provider** coverage for preventive services are subject to coinsurance and the deductible:

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** comprehensive support and counseling from trained providers, as well as access to breast feeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic** and interpersonal violance screening and counseling for all women
- **FDA-approved contraceptives**

- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabeties** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
- **Human Pampillomavirus (HPV) DNA Test** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-women visits** to obtain recommended preventive services

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia

- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

Rules When Preventive Services Are Provided as Part of an Office Visit Vary by Billing

If a preventive item or service is billed separately from an office visit, the Plan may impose cost-sharing requirements with respect to the office visit (but not the preventive item or service).

If a preventive item or service is not billed separately from an office visit, whether cost-sharing requirements may apply to that office visit depends on the primary purpose of the office visit. If the primary purpose is to obtain the preventive item or service, the Plan cannot impose cost sharing. If the primary purpose is not the delivery of the preventive item or service, the Plan may impose cost sharing for the office visits. For example, if a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the plan can charge a copayment for the office visit because the blood pressure check was not the primary purpose of the visit.

Medical Management requirements will still apply to preventive services.

PLEASE NOTE: The plan will cover qualified individuals that participate in an approved experimental and/or clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This also includes coverage of routine patient costs for items and services furnished in connection with participation in the trial. Members would need to call AMM to obtain the Fund's certification prior to obtaining these services.

Prescription Drug Coverage

The retail prescription card program allows you to go to a retail pharmacy and offers coverage after a $15 co-payment for generic drugs, a $30 co-payment for formulary brand name drugs, and a $45 co-payment non-formulary brand name drugs for up to a 34 day supply.

Prescriptions under a home delivery mail order service are covered for up to a 90 day supply, after a $30 co-payment for generic drugs, a $60 co-payment for formulary brand name drugs, and a $90 co-payment for non-formulary brand name drugs.

Vision Care Coverage

Covered for up to a maximum payment of $200 every 24 months for eyeglasses or contact lenses and/or an eye examination.

Vision Care claims should be submitted on the vision claim form. If you do not have a vision claim form please contact your local union office or call (888) 771-9075.

How the Plan Works With Other Health Care Coverage

Coordination of Benefits

Your Plan has a **Coordination of Benefits (COB)** provision that determines how payments are made if you or your dependents are covered by more than one health care coverage plan. Like most health care coverage, your Plan follows the "primary" and "secondary" rules of coverage. This means that in each case, the coverage that is considered primary pays claims first to the full extent of its coverage. Then, the secondary coverage pays an additional amount, up to the full extent of its coverage. Coverage is up to but never more than 100% of the actual covered charges.

If you purchase an individual health care policy, including Medicare supplementary coverage, that coverage is always primary and the Fund's coverage is secondary.

If the coverage does not have a coordination provision, that coverage is considered primary and always pays claims first. If both coverages have coordination provisions:

- the coverage that covers the patient as an employee (non-dependent) is primary and therefore pays the employee's claim first, except that the coverage that covers the patient as a dependent of an active employee is primary to the coverage that covers the patient as a laid-off employee
- the coverage that covers the patient as a dependent is secondary and therefore pays the claim second, except as stated above
- when a dependent child is covered by the coverage of more than one parent and all coverages have a coordination provision, the coverage of the parent whose birthday occurs first in the calendar year pays the dependent child's claim first and the coverage of the parent whose birthday occurs later in the year pays the dependent child's claim second. If both parents have the same birthday, the plan that has covered the parent longer pays the dependent child's claim first.

However, where the parents are divorced or separated and both coverages have coordination provisions, payment will be made as follows:

- the coverage of the parent with custody pays the claim first
- the coverage of the step-parent with custody pays the claim second
- the coverage of the non-custodial parent pays the claim last.

If there is a court decree that states otherwise, that court decree will govern.

If an individual is covered as a result of having purchased continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), and is also covered under a new or current employer's group plan, the following shall be the order of benefit determination:

- the plan covering the person as an employee (or as that employee's dependent) pays the claim first,
- the coverage purchased under the plan covering the person as a former employee (or as that employee's dependent) provided according to the provisions of COBRA pays the claim second.

Medicare Coverage

Medicare is the federal government's health insurance program for individuals age 65 and older. Individuals under age 65 who are disabled may also be entitled to Medicare.

If you are working in covered employment for an employer with 20 or more employees, and you are entitled to Medicare, the Plan will provide its full health care coverage first and Medicare will pay second. If you are working in covered employment for an employer with less than 20 employees, Medicare will provide coverage first and the Plan will pay second.

To the extent that it is legally permissible, if your dependent is eligible for Medicare, the Plan does not provide health care coverage for such Medicare eligible person.

Federal law requires that you have the right to elect to cancel your Plan health care coverage and have Medicare as your primary insurer. **If you make this election, all your Plan health care coverage will be canceled and you will have substantially less coverage.** This election is applicable only while you are age 65 or older and continue to work in covered employment. It does not affect Weekly Disability Income and Life Insurance Coverages, if you have these coverages. Any such election must be made in writing to the Fund Office.

There are special rules regarding how the Plan works with Medicare for individuals who have left covered employment.

Automobile No-Fault Coverage

If your injury is caused by an accident in a state that is covered by an automobile no-fault insurance law, or similar law relating to motor vehicle coverage and financial responsibility when not entitled a "No-Fault" law, the automobile no-fault insurance is responsible for paying the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile no-fault insurance up to the limits of its coverage.

Liability Coverage (Subrogation)

Conditional Benefit Payments

If you, your spouse or your eligible dependent has medical expenses as a result of an injury or accident for which a third party is, or may be, held responsible, the Fund will not cover such services but may, however make advance expense reimbursements to, or payments on behalf of, you, your spouse or your eligible dependent, subject to the Fund's subrogation rights. However, before any such reimbursements or payments will be conditionally made, you, your spouse or your eligible dependent (or your eligible dependent's legal guardian if your eligible dependent is a minor) must execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments and (2) the Fund's rights of subrogation, as provided for below.

Subrogation

If you, your spouse or your eligible dependent receives any benefits arising out of an injury or illness for which you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the Fund for such benefits shall be made on the condition and with the understanding that the Fund will be reimbursed out of any recovery you or your dependent receives or is entitled to receive. Such reimbursement will be made by you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) from: (1) any policy or contract from any insurance company or carrier (including your, your spouse's or your eligible dependent's insurer including coverage under an automobile insurance policy which includes your or your dependent's own underinsured or uninsured coverage and/or (2) any third party, plan or fund as a result of a judgment or settlement irrespective of whether or not the judgement or settlement or insurance recovery allocates any portion to the payment of medical benefits from the Fund or otherwise. You, your spouse or your eligible dependent on behalf of himself (or his guardian or estate) acknowledges and agrees that the Fund will be reimbursed in full before any amounts (including attorney fees incurred by you, your spouse or your eligible dependent or his guardian or estate) are deducted from the policy, proceeds, judgment or settlement.

The Fund will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your, your spouse's or your eligible dependent's insurer including coverage under an automobile insurance policy which includes your or your dependent's own underinsured or uninsured coverage) to the fullest extend permitted by any law. The amount of such subrogation will equal the total amount paid under the Fund arising out of the injury or illness for which you, your spouse or your eligible dependent (or your, your spouse's or eligible dependent's guardian or estate) has, may have or asserts a cause of action. In addition, the fund will be subrogated for attorney's fees incurred in enforcing its subrogation rights hereunder.

The Fund's subrogation shall apply irrespective of whether or not the injured party has been "made whole" from any other source and any State law make whole doctrine shall not apply.

Workers' Compensation Coverage

The Plan does not cover any charges for health care for which there is entitlement to Workers' Compensation or for injuries or illnesses that arise out of your employment. Workers' Compensation is a state administered program which offers coverage for health care costs and loss of earnings resulting from an occupationally related disease or accident.

Additional information about Workers' Compensation can be obtained from the State Industrial Commission or from the Amalgamated Occupational Safety and Health or Social Services Departments.

Government Coverage

If health care coverage is available for any condition or treatment covered by a government program (such as through a state hospital), or pursuant to any federal, state or municipal law, coverage under the Plan will not be provided. Except as provided elsewhere herein, Medicare shall not be deemed to be such a government program.

On April 7, 1986, a Federal Law, The Consolidated Omnibus Budget Reconciliation

How to File A Health Care Claim

What Is A Claim?

A claim is a request for benefits submitted in accordance with Fund rules.

Claim Type Definitions

There are several categories of claims:

- **Urgent Care Claim** - An urgent care claim is any claim for medical care or treatment with respect to which, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered dependent or, in the opinion of the treating physician with knowledge of the medical condition, would subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.
- **Pre-Service Care Claim** - A pre-service care claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as pre-certification) of the benefit in advance of obtaining medical care.
- **Post-Service Care Claim** - A post-service care claim is a claim for a benefit under the Plan that is not a pre-service claim. It involves the submission of bills by the patient or their authorized representative for care or services already rendered. An itemized bill forwarded by the provider who has a right to balance bill (for charges other than co-insurance and deductibles) is considered to be a claim for benefits.

- **Concurrent Care Claim** - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Under the Plan, a claim for benefits means a request for a Plan benefit or benefits made by you or your authorized representative in accordance with the following claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Your interactions with participating providers, panel providers, pharmacists or any other health care provider under the Plan will not be treated as a claim for benefits. In addition, a request for a prior approval of a benefit that does not require prior approval by the Plan or an inquiry about Plan eligibility is not a claim for benefits. You must file a claim for benefits in accordance with the claims procedures listed below in order to appeal a claim under the Plan.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Plan Administrator in writing of that person's designation. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim. If an authorized representative is designated, any subsequent communication will be made consistent with that authorization.

You may file any claim for benefits, including ones for concurrent care, pre- service care, or post-service care, yourself or through your authorized representative. Any of these types of claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone, or by U.S. Mail, by hand delivery or by facsimile. If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the Plan may require in support of your claim.

The Plan Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing.

How To File a Health Care Claim

An Amalgamated Life health benefit identification card is issued to you when you first become covered. Use this card when you visit any health care provider.

All claims, except for those submitted electronically, must be submitted in writing to the address set forth on the back of your Amalgamated Life identification card and must include the participant name, social security number and the patient name. They must also be signed by the patient or authorized representative. Most providers will submit their standard computerized form or submit their claim electronically. If you are the one filing a claim you must obtain an appropriate claim

form. The appropriate claim form is available from the Fund office or your Union Joint Board or Local Office.

In order to appoint an authorized representative the patient must complete and return an Authorized Representative form which can be obtained from the Fund office or your Union Joint Board or Local Office.

In some situations, you must call Alicare Medical Management. Please see the section in your Summary Plan Description Booklet called "Medical Certification Program".

A claim must be filed within two years from the date the expense was incurred. Proof of claim must include an itemized bill including date, type and charge for each service rendered.

The Fund office or its administrator makes all claim decisions. Payment will be made to the facility or health care provider unless receipts are submitted showing that the bill has already been paid, in which case payment will be made directly to the patient or legal guardian. Adverse claims decisions may be appealed (see "Your Right to Appeal").

Your COBRA Rights

Act (Public Law 99-272, Title X, commonly known as COBRA), was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you of your rights and obligations under the continuation coverage provisions of the law. You and your dependents should take the time to read this section carefully.

Important Note: You will be required to pay for this continuation coverage. The Plan will not pay your premium. The cost of full individual continuation coverage will be 102% of the cost of group coverage, unless a federal subsidy applies. If you are eligible according to the rules set forth below to purchase the additional 11 months of coverage available to disabled employees and dependents, the cost will be 150% of the group coverage for those 11 months. However, you will not be required to pass a medical examination or any other test of insurability.

If you are employed by an employer who contributes to the Amalgamated National Health Fund, you have a right to choose this continuation coverage if you lose your group health coverage because of any of the following qualifying events:

1) A reduction in your hours of employment; or
2) The termination of your employment (for reasons other than gross misconduct on your part).

If you are a covered spouse of an employee covered by the Amalgamated National Health Fund, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Amalgamated National Health Fund for any of the following qualifying events:

1) The death of your spouse;
2) The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
3) Divorce or legal separation from your spouse; or
4) Your spouse becomes entitled to Medicare.

In the case of a covered dependent child of an employee covered by the Amalgamated National Health Fund, he or she has the right to continuation coverage if group health coverage under the Amalgamated National Health Fund is lost for any of the following qualifying events:

1) The death of a parent;
2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3) Parent's divorce or legal separation;
4) A parent becomes entitled to Medicare; or
5) The dependent ceases to be a "dependent child" under the Amalgamated National Health Fund.

A newborn or adopted child will automatically be extended COBRA coverage if a parent already has COBRA coverage. This may involve an increase in the COBRA premium charged. In addition, a newborn child or an adopted child (or the child's custodian or guardian) may elect to continue COBRA coverage for up to 18 months or 36 months in accordance with the rules set forth below if the parent(s) are no longer entitled to COBRA. In effect, the newborn or adopted child has an independent right to continue for up to 18 or 36 months after the initial qualifying event.

Under the law, the employee or a family member has the responsibility to inform AliCare, Inc. of a divorce, legal separation, or a child losing dependent status under the Amalgamated National Health Fund within 60 days of the event or the date on which coverage would be lost because of the event. Your employer has the responsibility to notify AliCare, Inc. of the employee's death, termination of employment or reduction in hours, or Medicare entitlement. **(However, we urge you — the employee or family member — to notify the Plan of any and all qualifying events, in case your employer fails to do so).** If you or your family members fail to timely notify the Plan Administrator of a qualifying event you will lose the right to elect COBRA coverage. Similarly, your and your family members' eligibility for COBRA will not commence until your employer has notified the Plan Administrator that a qualifying event has occurred.

When AliCare, Inc. is notified that one of these events has happened, AliCare, Inc. will, in turn, notify you that you have the right to choose continuation coverage. Alicare, Inc. will notify you within 90 days of receiving notification of a qualifying event. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described or the date you receive this notice, to inform AliCare, Inc. that you want continuation of coverage. You will have 45 days from the date you notify AliCare, Inc. that you wish to purchase continuation coverage to pay your first month's premium.

If you do not choose continuation coverage, your group health insurance coverage will end. However, your other eligible dependents may elect the self-pay continuation coverage independent of your rejection.

If you choose continuation coverage, the Amalgamated National Health Fund will give you coverage which, as of the time coverage is being provided, is identical to the coverage being provided by the Plan to similarly situated employees and family members.

If you are a covered employee or the dependent of a covered employee and you lost group health coverage because of termination of employment (for any reason other than gross misconduct) or a reduction in hours, you may purchase continuation coverage for up to 18 months from your last day of covered employment.

Individuals who are disabled on the date of their qualifying event or within 60 days thereafter, if that event was due to termination of employment or a reduction in hours, and who are determined to be eligible for a Social Security disability pension within 18 months of the qualifying event, may extend the maximum period of coverage for up to 29 months.

If any eligible beneficiaries (you, as a covered employee, your spouse, or any dependent child) are entitled to Social Security disability benefits at the time of a qualifying event or within 60 days after a qualifying event, you may purchase an additional 11 months of COBRA as a disabled person (for a total of 29 months).

The additional 11 months of COBRA may be purchased not only for the disabled person but also for other covered family members who are not disabled (subject to the applicable premium).

To obtain the additional 11 months of COBRA coverage, the disabled person (employee, covered spouse or dependent child) must apply for social security disability benefits before the end of the 18 month continuation coverage period and must notify the Fund Office within the original 18 month continuation period and within 60 days after the Social Security Administration awards Social Security benefits to the disabled person.

If another qualifying event occurs within 18 months after the termination of employment or reduction in hours, the required continuation coverage will be extended until 36 months after the termination of employment or reduction in hours. If you lost group health coverage for any other reason, you may maintain continuation coverage for up to 36 months.

Your continuation coverage may also end for any of the following reasons:

1) Your employer no longer provides group health coverage to any of its employees;

2) The premium for your continuation coverage is not paid within 30 days of the due date;

3) You become covered under another group health plan as an employee or otherwise; or

4) You became entitled to Medicare benefits.

The law says that, at the end of the 18, 29 or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if a conversion option is otherwise available to similarly situated individuals under the Amalgamated National Health Fund.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions about continuation coverage, please contact AliCare, Inc., 333 Westchester Avenue, White Plains, NY [illegible]. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify AliCare, Inc. at the above address.

What The Plan Does Not Cover

The Plan does not cover:

- Over-the-counter (OTC) drugs except as specified otherwise herein and where prescribed by a physician
- Vitamins including B-12 injections
- Hearing Aids
- Biofeedback
- Acupuncture
- Hypnotism
- Pastoral Counseling
- Routine foot care, except as may be medically necessary and appropriate for the treatment of certain illness or accidental injury, including treatment for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet
- Private room charges (unless deemed to be medically necessary)
- Rest or convalescent cures
- Surgery, sex hormones, and related medical and psychiatric services to change sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders
- Wigs, toupees, hair transplants, hair weaving, or any drug used to eliminate baldness unless deemed medically necessary and appropriate
- Education and Training, unless otherwise specified herein,
- any charges which are deemed not medically necessary to the diagnosis or treatment of an illness or injury, or are educational in nature or primarily for the purpose of medical research, or are deemed to be experimental or investigational or not medically appropriate as determined by the Fund's Medical Director, using generally accepted standards of medical practice, or in accordance with government guidelines which include, but are not limited to:
  1) Whether the Food and Drug Administration approved the drugs for the specified usage,
  2) Whether there is sufficient information to allow the Fund's Medical Director to decide if the procedure is safe and efficacious,
  3) Whether available evidence demonstrates a net beneficial effect,
  4) Whether the procedure is as safe and efficacious as existing alternatives,
  5) Whether the procedure satisfied criteria (3) and (4) outside of the research setting
- any charges which are in excess of the Fund's reasonable and customary fee or maximum recognized charge for the services rendered
- any confinement or care which is primarily for custodial purposes, long-term care, or care during the non-acute stages of an illness
- any charges for services for which no payment was required
- most charges for dental procedures, dental X-rays, or for treatment of temporomandibular joint dysfunction/pain syndrome

- any charges for personal convenience items such as television, radio or telephone, or for personal hygiene items
- any charges for non-reusable medical supplies unless otherwise specified herein
- any charges for treatment for dental treatment except as otherwise specified
- any charges for blood where blood replacement is available
- any charges for private duty nursing or home health aides unless otherwise specified herein
- any charges for psychological or educational testing unless specifically covered under preventive services
- any charges for non-FDA-approved contraceptives
- any charges for treatment of infertility, including charges for in-vitro fertilization, or reversal of elective sterilization
- any charges for treatment of any kind of obesity, weight reduction or dietary control, including stomach stapling (gastroplasty) unless the condition is considered life threatening
- any charges for treatment or services unless specifically stated as covered herein
- any charges resulting from an act of war, whether declared or undeclared or caused during service in the armed forces of any country
- any charges for an illness or injury arising out of or in the course of an employee's employment
- any charges for penalties assessed by a primary medical plan, Medicare or a Health Maintenance Organization (HMO) due to failure to obtain from the primary plan precertification, second surgical opinion or for any other reason
- any charges for cosmetic surgery to improve the appearance of the individual, except in connection with a mastectomy, unless due to functional impairment as a result of disease or trauma or congenital or developmental abnormality. Cosmetic surgery includes, but is not limited to: breast enlargement or reduction, liposuction, rhinoplasty, ear pinning, facial lifts, radial keratotomy and lasik surgery
- any charges related to, or resulting from, or occurring during the commission of a crime or illegal act by the covered person
- any charges incurred in a country or principality outside the United States, where health care is available without charge
- any hospital inpatient day where there is a non-emergency hospital inpatient admission on a weekend (Friday, Saturday, Sunday), unless surgery or other vital services are performed within 24 hours of that day

4. How Your Rights Are Protected

As a participant in the Amalgamated National Health Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified location, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room, Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights
- You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of your and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Your Right To Appeal

If your entire claim, or part of your claim is denied, you have the right to appeal. The following appeals procedures apply only to claims for benefits provided under this Plan to Participants.

Appeal of Adverse Benefit Determination

If you disagree with the determination, you may request an appeal of such denial by written request filed with the Fund within one hundred and eighty (180) days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally. No legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final decision by the Plan Administrator has been rendered or has been deemed rendered.

The following appeal procedure applies if you are appealing the adverse claim determination under a claim for weekly disability income governed by the New York State Law:

> If a claim is rejected or not paid, the employee should complete the reverse side of the Notice of Rejection (sent by the employer/carrier/the Special Fund, within 45 days of its receipt of the claim) and mail it within 26 weeks to the Disability Benefits Bureau of the Workers' Compensation Board (the Board). The address is located on the back of the rejection notice, and in the back of this brochure. Where necessary, the Board will obtain further information and may hold a hearing on the claim. Benefits will be paid if a claim is determined proper and valid.

Review Process

In connection with your right to appeal the initial determination regarding your claim, you:

- will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- will be provided, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination;
- will be provided with the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- are entitled to have your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial; and
- are entitled to a review that is conducted by a different individual, who is neither the individual who made the adverse benefit determination, nor the subordinate of such individual.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and you by telephone, facsimile, or other available expeditious methods.

Timeframes for Review and Appeal

The Fund must issue a review decision on your appeal according to the following timetable:

- **Urgent Care Claims** - not later than seventy-two (72) hours after receiving your request for a review.
- **Concurrent Care Claims** - an appeal of a concurrent care claim will be treated as either an urgent care claim, pre-service care claim, or a post-service care claim, depending on the facts.
- **Pre-Service Care Claims** - not later than thirty (30) days after receiving your request for a review.
- **Post-Service Care Claims** - The Appeals Committee meets four times each year. If your appeal is received more than thirty days prior to the next Appeals Committee Meeting, it will be considered at that meeting. If your appeal is received within thirty days of the next Appeals Committee Meeting, your appeal will be considered at the meeting that follows. You will receive a written decision of the outcome of your appeal within 30 days of the decision. If you lose your appeal, you have the right to file suit in State or Federal Court under section 502(a).

Timeframes for Notification of Initial Benefit Determination

- **Urgent Care Claim** - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but in no event more than seventy-two (72) hours after the Plan has received the claim. If the claim does not include sufficient information for the Plan Administrator to make an intelligent decision or you have failed to follow the Plan's claim procedures, you or your representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. You will also receive a copy of the proper procedures to be followed. You will have at least forty-eight (48) hours to respond to this request. The Plan Administrator must inform you of its decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) receiving the additional information or (ii) the end of the period you had to provide the specified information.
- **Concurrent Care Claim** - you or your authorized representative will be notified of the Plan's decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If the claim to extend the course of treatment or the number of treatments involves urgent care, the Fund will notify you, whether adverse or not, within twenty-four (24) hours after receiving the claim provided that the claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or the number of treatments. You will be given time to provide any additional information required to reach a decision.

- **Pre-Service Care Claim** - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date the Plan receives the claim. This 15-day period may be extended by the Fund for an additional fifteen (15) days if the extension is required due to matters beyond the Fund's control. If such an extension is necessary, you will receive written notice of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision prior to the expiration of the 15-day period. If the extension is necessary due to your failure to submit the information necessary to decide the claim or your failure to follow the Fund's claim procedures, you will receive a notice that specifically describes the required information or the proper procedures to be followed. You will receive notification of your failure to follow the Fund's claim procedures not later than five (5) days after your claim is filed. You will have at least forty- five (45) days to provide to the Fund any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.
- **Post-Service Care Claim** - you or your authorized representative will be notified of the Plan's decision on the claim. This notification will be issued no later than thirty (30) days after the Fund receives the claim. The Fund may extend this 30-day period one time for up to fifteen (15) days if the extension is required due to matters beyond the Fund's control and if the Fund notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least forty-five (45) days to provide to the Fund any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notification of Initial Benefit Determination

If your claim for benefits has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reason(s) for such denial with references to the specific plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such information is necessary);
- a description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- that if an internal rule, guideline, protocol, or other similar criterion was relied

upon in making the adverse determination, you will receive a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge, upon request; and
- that if the benefit determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning a claim involving urgent care, you will also receive a description of the expedited review process applicable to such claim. In addition, if your claim involves urgent care, the information described in the first three items above may be provided orally, provided that a written or electronic notification is furnished to you not later than three (3) days after the oral notification.

Manner and Content of Benefit Determination on Review

If your appeal under this Fund has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reasons for the decision;
- references to the specific plan provisions on which it was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement describing your right to bring a civil action under section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge, upon request;
- if the benefit determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

The decision of the Trustees of the Fund (or its designated committee) on review shall be final and binding on all parties.

Assistance With Your Questions:

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Determination of Benefits

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Plan Administrator in its sole discretion determines you are entitled to receive.

External Appeal*

I. YOUR RIGHT TO AN EXTERNAL APPEAL

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and

- You must have received a final adverse determination through the [first level of the] Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation - your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered);or

- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

IV. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS OUT-OF-NETWORK

If the Plan has denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you satisfy the following three (3) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract;

- You must have requested pre-authorization for the out-of-network treatment; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the

adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

V. THE EXTERNAL APPEAL PROCESS

If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment [, or is an out-of-network treatment] you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment [or an out-of-network treatment] the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

VI. YOUR RESPONSIBILITIES

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the Plan. You may appoint a representative to assist you with your external appeal request; however, Plan may contact you and request that you confirm in writing that you have appointed such representative.

Your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Your HIPAA Rights (Medical Only)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described below.

Creditable coverage

Under HIPAA, when you and your dependents no longer have coverage under this Medical Plan, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy. You can request a copy of the certification by contacting the Plan Administrator at 888-771-9075.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

Your special enrollment rights

If you decline to enroll in this Medical Plan for yourself and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in this Plan's coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member loses eligibility under another plan or because COBRA coverage has ended. In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you also may be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you will have to wait until the next open enrollment period - or have another qualified status change or special enrollment right - to enroll.

To meet IRS regulations and plan requirements, the Plan Administrator reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying event.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected Health Information ("PHI") is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you or your physical or mental health or condition in the past, present or future.

This Notice of Privacy Practices (the "Notice") describes how we may use and disclose your PHI. It also describes our obligations and your rights to access and control your PHI. We are required by law to (i) maintain the privacy of PHI; (ii) provide you with this Notice of our legal duties and privacy practices with respect to PHI; (iii) abide by the terms of the notice currently in effect; and (iv) notify you of any breach of your unsecured PHI.

Mandatory Uses and Disclosures

We are required to disclose your PHI to you, at your request, to allow you to exercise your rights regarding your PHI, as described below.

We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services (the "Secretary"), if the Secretary requests such information, to investigate or determine our compliance with federal privacy regulations.

Permitted Uses and Disclosures

The following categories describe different ways that we may use and disclose your PHI without your consent or authorization. Regardless of whether health information is used or disclosed for purposes of treatment, payment or health care operations, we will use or disclose only the minimum amount of information as may be necessary for these purposes.

- **Treatment**. We may use or disclose your PHI to facilitate treatment. Treatment means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another. As a group health plan we do not provide treatment. We may disclose the fact that you are eligible for benefits to a provider who contacts us to verify your eligibility.

- **Payment**. We may use and disclose your PHI to facilitate payment. Payment includes the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage and administrative responsibilities, to provide benefits under the plan and to obtain and provide reimbursement for the provision of health care. For example, a bill may be sent to you or a third party payer. The information on the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may also use your PHI to decide whether a particular treatment is medically necessary and what the payment should be. During this process we may disclose this information to your provider.

- **Health Care Operations**. We may use and disclose your PHI during the course of running the Plan - that is, during operational activities, including, but not limited to, quality assessment and improvement, licensing, accreditation, performance measurement and outcomes assessment, health services research and preventive health, disease management, case management and care coordination. For example, we may use information about your claims to project future benefit costs or audit the accuracy of our claims processing functions. We may use your PHI to determine the cost impact of benefit design changes. We may also disclose your PHI to underwriters for the purpose of calculating premium rates and

providing reinsurance quotes to us, but if we do so your genetic information cannot be used or disclosed for this purpose.

- **Other Health Care Providers.** We may disclose your PHI to any hospital, nursing home, or other health care facility to which you have been admitted, to an assisted living or personal care facility of which you are a resident, to any physician providing you care, and to licensing or state agencies acting as a representative of the Medicare/Medicaid programs.

- **Others Involved in Your Care.** We may disclose your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if (i) the information is directly relevant to the family or friend's involvement with your care or payment for that care, and (ii) you have either agreed to the disclosure, we can reasonably infer from the circumstances, based on our professional judgment, that you do not object to the disclosure, or you have been given an opportunity to object to the disclosure and have not objected. You have the right to restrict information that is provided to such persons as more fully described below. We also may, under certain circumstances, use or disclose your PHI to notify or assist in the notification of a family member, your personal representative or another person responsible for your care of your location, general condition or death in accordance with applicable law. We may also disclose your PHI to any authorized public or private entities assisting in disaster relief efforts.

- **Emergency Treatment.** We may also use or disclose your PHI for treatment in emergency situations. In such emergencies, we will inform you in advance and provide you the opportunity to either agree to its use or disclosure, or to prohibit or restrict the use or disclosure of your PHI unless you are incapacitated or cannot otherwise agree or object, in which case we may use or disclose your PHI if it is in your best interest, as determined in the exercise of our professional judgment.

- **Business Associates.** We may disclose your PHI to our business associates and may allow our business associates to create or receive PHI on our behalf. We may disclose your PHI to our business associates, and may allow our business associates to create or receive PHI on our behalf, as each business associate that we retain is responsible for maintaining the privacy of your PHI.

- **As Required By Law.** We may use or disclose PHI when required to do so by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

- **To Plan Sponsor.** The Plan may disclose your PHI to the sponsor of the Plan. We may use or disclose your PHI to the Plan Sponsor as necessary to carry out administrative functions of the Plan. For example, we may disclose to the Plan Sponsor information to allow them to decide an appeal or review a subrogation claim. In addition, the Plan Sponsor may receive your PHI if you request that the Plan Sponsor assist you in filing or perfecting your claim for benefits under the

Plan. The Plan Sponsor may also receive your PHI if it is necessary to fulfill any fiduciary duties with respect to the Plan. When disclosing PHI to the Plan Sponsor, we will make reasonable efforts not to disclose more than the minimum necessary amount of PHI to achieve the particular purpose of the disclosure. In accordance with the Plan documents, the Plan Sponsor has agreed not to use or disclose your PHI: (1) other than as permitted in this Notice or as required by law, (2) with respect to any employment-related actions or decisions, or (3) with respect to any other benefit plan maintained by the Plan Sponsor.

In addition, we may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan.

- **Public Health Activities**. We may disclose your PHI for public health activities. These activities may include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with medical products; notifying you of recalls of products you may be using; and notifying you or another person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Victims of Abuse, Neglect or Domestic Violence**. We may disclose your PHI to an appropriate government authority if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will only make such disclosures if you agree or when required or authorized by law.

- **Health Oversight Activities**. We may disclose your PHI to a health oversight agency for oversight activities authorized by law. Oversight activities may include audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions and civil, administrative or criminal proceedings or actions.

- **Judicial or Administrative Proceedings**. We may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process, but only if we receive satisfactory assurance that reasonable efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement**. We may disclose PHI if asked to do so by a law enforcement official (i) in response to a court order, subpoena, warrant, summons or similar process; (ii) to identify or locate a suspect, fugitive, material witness or missing person; (iii) about an individual who is or is suspected to be a victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (iv) about an individual who has died if we have a suspicion that such death may have occurred as a result of criminal conduct; (v) about criminal conduct occurring on our premises; and (vi) in emergency circumstances to report a

crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors**. We may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. We may also disclose your PHI to funeral directors, as necessary to carry out their duties.

- **Organ, Eye and Tissue Donation**. We may use or disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue to facilitate organ or tissue donation and transplantation.

- **Research**. We may use or disclose your PHI for research purposes under certain circumstances.

- **To Avert a Serious Risk to Health or Safety**. Consistent with applicable law and standards of ethical conduct, we may use or disclose your PHI if we believe such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the public or another person.

- **Military and Veterans**. If you are a member of the armed forces or separated/discharged from military service, we may use and disclose your PHI when required by military command authorities or the Department of Veteran Affairs, as may be applicable. We may also release the PHI of individuals who are foreign military personnel to the appropriate foreign military authorities.

- **National Security and Intelligence Activities**. We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Workers' Compensation**. We may disclose your PHI to the extent necessary to comply with laws relating to workers' compensation and other similar programs that provide benefits for work-related injuries or illness without regard to fault.

- **Inmates**. If you are an inmate of a correctional facility or under the custody of a law enforcement officer, we may disclose your PHI to the correctional institution or the law enforcement officer.

Note: HIV-related information, alcohol and/or substance abuse records, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

Other Uses and Disclosures

Other uses and disclosures of your PHI not covered by this Notice will be made only with your written authorization. In addition, most uses and disclosures of psychotherapy notes and/or PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require your authorization

If you authorize us to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use your PHI for the reasons covered by your written authorization; however, we will not reverse any uses or disclosures already made in reliance on your prior authorization.

Your Rights With Respect to Protected Health Information

You have the following rights regarding your PHI:

Right to Inspect and Copy. Generally, you may inspect and/or obtain a copy of your PHI for as long as the PHI is kept by or for us. To inspect and copy your PHI, you must submit your request in writing to 333 Westchester Avenue, White Plains, NY 10604. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and/or obtain a copy of your PHI in very limited circumstances. If we deny your request to inspect and/or obtain a copy of your PHI, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

Right to Request Amendment. If you feel that your PHI is inaccurate or incomplete, you have the right to request that we amend it for as long as the PHI is kept by or for us. Your request must be made in writing to Plan Administrator. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that (i) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (ii) is not part of the PHI kept by or for us; (iii) is not part of the information that you would be permitted to inspect and copy; or (iv) is already accurate and complete. If we deny your request for amendment, you have the right to have a statement of disagreement included with the PHI and we have a right to include a rebuttal to your statement, a copy of which will be provided to you.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that we have made to others. This list will not include disclosures made for the purpose of treatment, payment, or health care operations, disclosures made to you or other disclosures exempted from the disclosure accounting requirements by the federal rules governing such disclosures. This is a list of disclosures of your PHI that we have made to others. The accounting will not include (i) disclosures made for the purpose of treatment, payment or health care operations; (ii) disclosures made to you; (iii) disclosures made pursuant to your authorization; (iv) disclosures made to friends or family in your presence because of an emergency; (v) disclosures made for national security purposes; (vi) disclosures incidental to otherwise permissible disclosures; and (vii) other disclosures exempted from the disclosure accounting requirements by the federal rules governing such disclosures.

Under HITECH, individuals will be entitled to receive an accounting of routine disclosures of PHI that is maintained in an electronic health records system, for the three-year period prior to the date of the accounting request. For disclosures made by a business associate, the covered entity can provide the accounting itself,

or, in the alternative, provide the individual with contact information for the business associate.

Your request must state a time period, which may not be longer than six years and may not include dates before September 23, 2013. The first list that you request within a 12-month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may chose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or a friend. Your request must state (i) what information you want to restrict; (ii) whether you want to restrict our use, disclosure or both; and (iii) to whom you want the restriction to apply. We are not required to agree to a restriction that you request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you regarding PHI in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically.

You may make any of the requests described above by calling 888-771-9075.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Plan Administrator. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

For More Information

If you have any questions regarding this Notice or the subjects addressed in it you may contact 888-771-9075.

Changes to this Notice

We reserve the right to revise the terms of this Notice and to make the revised notice applicable to PHI that we already have as well as PHI that we receive in the future. We will provide you with a copy of the revised notice via first class mail. We will also post a copy of the current notice on our website.

Effective Date

This Notice will become effective on September 23, 2013.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay 48 hours or less (or 96 hours or less).

Woman's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMOs provide this coverage, subject to applicable deductibles and coinsurance. If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you also will be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema.

Amendment / Termination Of The Plan

The Trustees of the Fund expect to continue this Plan indefinitely. They have the right, however, to amend or terminate the Plan at any time, including the portions of the Plan that pertain to participants who have retired. The Plan may also be terminated if the obligation of all employers to contribute to the Fund ceases.

Any amendment to the Plan may be made by an action consented to or taken by a quorum of Union-appointed Trustees and Employer-appointed Trustees.

Additional Board of Trustees Information

Noel Beasley, President
Chicago & Midwest Regional Joint Board - Workers United & Workers United
333 South Ashland Ave.,
Chicago, IL. 60607

Patrick Cronin,
Secretary
Chicago & Midwest Regional Joint Board - Workers United & Workers United
333 South Ashland Ave.,
Chicago, IL. 60607

David Eckwall
Senior VP of Human Resources
Compass Group
3 International Dr.
Rye Brook, NY 10573

John Fowler
International Automotive Component Group - Retired
210 Bruce Farm Rd.
Simpsonville, SC 29681

Richard Ellis, Vice President Labor Relations
Aramark
Labor Relations
1101 Market Street - 6th Fl.
Philadelphia, PA 19107

Lynne P. Fox, Vice President
Philadelphia Joint Board - Workers United
22 South 22nd St.
Philadelphia, PA 19103

Jean Hervey, Regional Director
Workers United
2639 Walnut Hill Ln.,
Ste. 203
Dallas, TX 75229

Julie Kelly
New York - New Jersey Regional Joint Board - Workers United
18 Washington Pl.
Newark, NJ 07102

Desmond Massey
Fox Rothchild LLP
75 Eisenhower Pkwy.
Roseland, NJ 07068

David Melman, Vice President
Pennsylvania Joint Board - Workers United
1017 Hamilton St.
Allentown, PA 18101

Homi Patel, Retired Chairman & CEO,
Hartmarx Corp.
150 Field Dr., Ste. 300
Lake Forest, IL 60045

Warren Pepicelli,
International Vice President
New England Regional Joint Board - UNITE HERE
33 Harrison Ave.
Boston, MA 02111

Harris Raynor, Vice President
Southern Regional Joint Board - Workers United
4405 Mall Boulevard,
Ste. 600
Union City, GA 30291

Edgar Romney,
Secretary-Treasurer
Workers United - c/o Amalgamated Bank
275 Seventh Ave., 6th Fl.
New York, NY 10001

Richard Rumelt,
International Vice President
UNITE HERE - c/o New England Joint Board
33 Harrison Avenue,
8th Fl.
Boston, MA 02111

Anthony Sapienza,
President
Joseph Abboud Apparel Corp.
689 Belleville Ave.
New Bedford, MA 02745

Steven E. Thomas,
President
National Association of Blouse Manufacturers
225 West 34th St.,
Ste. 1816
New York, NY 10122

Cristina Vazquez, Vice President
Western States Regional Joint Board - Workers United
920 S. Alvarado St.
Los Angeles, CA 90006

APPENDIX C

MIDWEST
ORTHOPAEDICS
at RUSH

Managed Care/HMOs

In This Section +

Guide To Managed Health Care

More and more of our patients are covered by "managed care" health insurance. Managed care plans can usually be identified by the acronyms HMO, PPO, MCO, PHO, OHP and the like. Our physicians are increasingly being asked by insurance companies to see managed care patients. They are often asked to sign managed care insurance company contracts, to which we agree, in exchange for patients insured by the plan to be referred to us.

Most managed care plans have requirements for us to follow. Should we fail to follow those requirements, we can be prohibited from seeing patients covered by that plan. You, likewise, could incur increased health care costs—costs not covered by your insurance.

Managed care plans often have one or more of the following requirements:

1. We see only those patients with insurance referrals from a primary care physician (PCP);
2. There is a co-pay obligation by the patient, and;
3. Prior authorization and/or a second opinion are needed before surgery is performed.

There is a good chance that your insurance plan has one or more of these managed care requirements. If it does, we are obligated to follow them. These requirements may not always be pleasant or your medical treatment as timely as you would like, but they may be a part of

your managed care program. Here are some common features of managed care plans:

Prior Referral Before Treatment

An increasing number of managed care plans require that you first obtain an insurance referral from your primary care physician (PCP) before being permitted to visit with us. These insurance referrals may take seven (7) days, or more, to obtain. Specialists who diagnose or treat managed care patients without prior referrals may not be reimbursed by the insurance plan for their services and risk being excluded from seeing plan patients at all. Patients who see specialists without insurance referrals risk being 100% responsible for the costs.

Co-Payments

Co-payments are the portion of the fee for services for which the member is responsible. Insurance companies believe that having the insured patient responsible for a portion of the total bill will affect the patient's decision to see a doctor. Our contracts with managed care companies place upon us a responsibility to collect the required co-payments.

Prior Authorization

Being insured under managed care creates the responsibility of obtaining authorization from the insurance company before surgery or hospitalization. We are willing to assist in obtaining the necessary authorization. In some cases, the managed care company requires the opinion of a second physician before surgery is authorized. Obtaining authorization, or arranging for a second opinion, may create lengthy delays.

Third-Party Pay Responsibility

The cost of medical care for some patients may be covered by some source other than their private insurance company. On-the-job injuries, and injuries received in a motor vehicle accident, are a couple examples. Despite third-party responsibility for the payment of medical expenses, we are still required by our managed care contracts to obtain the managed care referral for treatment and prior authorizations before services are performed. As such, patients still need to obtain this referral before being seen.

Medical Care Delivery is Changing

We are no longer able, in non-emergency situations, to schedule and treat patients as we used to do. Managed care insurance programs require all of us, patient and physician alike, to obtain referrals or permission before a patient can be treated. Please understand that we are trying to make the system work as it is designed. We are pleased to have you as a patient; however, before we can treat you it may be necessary to comply with the managed care guidelines of your insurance company.

MANAGED CARE PLANS

PLAN	PRODUCT
Aetna	HMO/PPO/POS/EPO
Beech Street	PPO
Blue Cross Blue Shield - HMO Illinois	HMO*
Blue Cross Blue Shield of Illinois	PPO
Blue Cross Blue Shield Medicare Advantage PPO	Medicare FFS/PPO
CIGNA Healthplan of Illinois, Inc.	HMO/POS/PPO
Great West	PPO
Health Network	PPO
Healthcare's Finest Network	PPO
HFN	PPO/EPO
Humana Health Care Plans	PPO/POS/HMO*
Multiplan	PPO
PPONext	PPO
Preferred Network Access	PPO
Private Healthcare Systems	PPO
Three River Provider Network	PPO
UnitedHealthcare	HMO/PPO
United Healthcare Group Medicare Advantage (Medicare State of IL Retirees)	Medicare FFS/PPO

*for selected HMO sites

If you do not see your health plan listed above, please contact Midwest Orthopaedics at Rush at 877 MD BONES (877.632.6637) for further clarification.

MOR is proud to be designated as a Blue Cross Blue Shield Blue Distinction® Center for Knee and Hip Replacement. Blue Distinction Centers demonstrate an expertise in quality care, resulting in better overall outcomes for patients, by meeting objective clinical measures developed with input from expert physicians and medical organizations.

877 MD BONES (877.632.6637)

contact@rushortho.com

APPENDIX D

REDACTED

Blue Cross®
Blue Shield®

JIAN REN HE

Member ID
DHY000[redacted]

Group No: 000DHY834
Group Name: Amalgamated National Health Fund
Plan Code: 834 / 332

Co-pay Information-
Physician Visit: $15.00
Specialty, Urgent Care,
Chiropractic, Therapy: $25.00

APPENDIX E

HE, JIAN REN 09/26/56 #1526016

* 2138951w12576 A-Billing

MIDWEST
ORTHOPAEDICS
at RUSH

Patient Lien Agreement and Letter of Protection (BCBS)

This letter agreement is being signed in connection with services that are to be rendered by Midwest Orthopaedics at Rush, LLC ("MOR"). This letter is being freely executed and pertains to services that are to be rendered by MOR on or after the date set forth below. I hereby agree to protect any liens that are placed by MOR in connection with unpaid balances that may be due on my account. I understand that MOR shall be entitled to a recovery in connection with such liens from any settlement or other resolution of liability in connection with the claim(s) arising out of my accident/injury. I further understand and agree that MOR reserves the right to treat the third party payor as the primary payor and I acknowledge and agree that MOR reserves the right to seek payment as provided by the Illinois Health Care Services Lien Act (770 ILCS 21/1, *et seq.*) as against any responsible third party for services rendered to me.

I specifically understand that I am agreeing to the provision of the lien(s) and that I am making a voluntary and knowing waiver of my health insurance benefits with Blue Cross and BlueShield of Illinois ("BCBSIL"). I understand, and am hereby being informed, that I am not obligated to execute this letter in order to receive treatment from MOR. I understand that MOR is intending to seek payment from me or a third-party, which may include a recovery of funds from any settlement or award from any such third-party regardless of whether such third-party admits or denies liability for my claims. I further confirm my understanding both that MOR will seek its full billed charges or other appropriate amounts from me or any such third-party and will not be submitting bills at any discounted rates that were agreed upon with BCBSIL, and that BCBSIL will not have any responsibility for payments in connection with any healthcare services that are covered by or provided in connection with this waiver letter that, if it were not for the execution of this waiver letter, would have otherwise been considered to be eligible for benefits and/or payable by BCBSIL under my health benefits plan with BCBSIL. I understand and agree that this waiver of the right to submit claims to BCBSIL is applicable even if no third-party is ultimately deemed to be liable for the payment.

I understand and agree that I have a right to rescind this waiver letter at any time, but that any such rescission of this waiver letter shall not be retroactive and shall not limit or reduce the effectiveness of this waiver letter as to any services provided prior to the date of rescission.

REDACTED

HE, JIAN REN 09/26/56 #1526016

*2138951w12576 A-Billing

My signature below confirms my understanding of and agreement to the terms that are set forth in this Patient Lien Agreement and Letter of Protection. I understand that if I have any questions regarding my accounts or the charges associated with any services that are provided by MOR, I may contact MOR at (708)236-2607.

[redacted]

Date 1/29/18

Jian Ren He
Patient Name

Accepted by:

MIDWEST ORTHOPAEDICS AT RUSH, LLC

Signature

Printed Name

Date

APPENDIX F

NOTICE OF UPDATED PHYSICIAN'S LIEN

TO: Law Office of Jonathan S. Lustig
State Farm Claim #: 131429C38
Jian Ren He #: 1526016

PLEASE TAKE NOTICE that the undersigned, a duly licensed and practicing physician in the State of Illinois, has rendered or will render services by way of treatment to **Jian Ren He** residing at **2237 S. Canal Apt. 2E Chicago, IL. 60616** for injuries sustained on **09/12/2017.** The following named party or parties may be liable to make compensation to said injured person on account of any claims or rights of action which said injured person may have:

Name of Parties Who May Be Liable:	Address:
Law Office of Jonathan S. Lustig	**200 E. Randolph St. Ste. 5100 Chicago, IL. 60601**
State Farm Claim #: 131429C38	**PO Box 106171 Atlanta, GA 30348**
Jian Ren He	**2237 S. Canal Apt. 2E Chicago, IL. 60616**

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the law of the State of Illinois relating to Physician's Liens, upon all claims and causes of action of said injured person for his reasonable charges for services rendered up to the date of payment of such damages.

PROOF OF SERVICE

Nancy Aranda (708)236-2724
Brenda Thurman(708) 236-2633
Jackie Moreno (708)236-2779
Authorized Representative on behalf of:

STATE OF ILLINOIS
COUNTY OF COOK

Dr Verma, Gross, Sweeney et al
Medical Service Provider(s) at
Midwest Orthopaedics at Rush, LLC
1611 W Harrison St
Chicago Il 60612

This Physician lien represents a balance of $9,980.59. This amount is subject to change. Please contact our office at 708-236-2724 for the current balance before settlement.

Nancy Aranda, Brenda Thurman & Jackie Moreno, being of legal age, deposes and says that on **June 18th** she served the foregoing Notice of Physician's Lien upon the above-mentioned person(s) by: Mailing a true copy thereof by Certified Mail to the above-named person(s) at their respective addresses shown above.

Sworn and subscribed to before me this **18th** day of **June 2019**

Seal

OFFICIAL SEAL
LATOYNIA TOLSTON EDDINS
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/12/20

Notary Public

Claim ID 332863										
332863	04/30/2018	05/02/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$0.00		
						OUTSTANDING	$0.00	$0.00	$0.00
332863	04/30/2018	05/02/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$0.00		
						OUTSTANDING	$0.00	$0.00	$0.00
332863	04/30/2018	05/02/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$42.00		
332863	04/30/2018	05/17/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-35.70		
						OUTSTANDING	$6.30	$0.00	$0.00
Claim ID 388729										
388729	06/25/2018	07/03/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$100.00		
388729	06/25/2018	07/23/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-85.00		
						OUTSTANDING	$15.00	$0.00	$0.00
Claim ID 424674										
424674	08/06/2018	08/15/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$287.00		
						OUTSTANDING	$287.00	$0.00	$0.00
424674	08/06/2018	08/15/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$166.00		
424674	08/06/2018	09/04/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-161.72		
						OUTSTANDING	$4.28	$0.00	$0.00
424674	08/06/2018	08/15/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$42.00		
						OUTSTANDING	$42.00	$0.00	$0.00
Claim ID 477532										
477532	10/01/2018	10/09/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$166.00		
477532	10/01/2018	10/26/2018	TRANSFERIN		PATIENT	NIKHIL VERMA	$-25.00		$25.00
477532	10/01/2018	10/26/2018	PAYMENT		PATIENT	NIKHIL VERMA			$-25.00
						OUTSTANDING	$141.00	$0.00	$0.00
Claim ID 618204										
618204	02/25/2019	03/13/2019	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$2,288.00		
						OUTSTANDING	$2,288.00	$0.00	$0.00
Claim ID 622155										
622155	02/25/2019	03/18/2019	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$166.00		
622155	02/25/2019	03/18/2019	TRANSFERIN		PATIENT	NIKHIL VERMA	$-25.00		$25.00
622155	02/25/2019	03/18/2019	PAYMENT		PATIENT	NIKHIL VERMA			$-25.00
						OUTSTANDING	$141.00	$0.00	$0.00
Claim ID 639011										
639011	03/11/2019	04/19/2019	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$100.00		
						OUTSTANDING	$100.00	$0.00	$0.00
						TOTAL CHARGE OUTSTANDING AS OF 06/17/2019	**$9,980.59**	**$0.00**	**$0.00**

MIDWEST ORTHOPAEDICS AT RUSH LLC

printed 06/17/2019 09:53 AM

MIDWEST ORTHOPAEDICS AT RUSH LLC
PO BOX 16852
BELFAST, ME 04915-4063
billing phone: (708) 236-2607

GUARANTOR NAME AND ADDRESS	PATIENT #	PATIENT NAME
JIAN REN HE 2237 S. CANAL, APT 2E CHICAGO, IL 60616-1162	1526016	JIAN REN HE
	DOB	HOME TELEPHONE
	09/26/1956	(312) 823-0739

Billing Summary

Claim ID	Procedure	Date of Service	Post Date	Type	Reason	Plan	Supervising Provider	Ins. 1	Ins. 2	Patient
Claim ID 220674										
220674		12/20/2017	01/11/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$143.00		
							OUTSTANDING	$143.00	$0.00	$0.00
220674		12/20/2017	01/11/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$378.00		
							OUTSTANDING	$378.00	$0.00	$0.00
Claim ID 249778										
249778		02/06/2018	02/06/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$28.00		
249778		02/06/2018	03/30/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-23.80		
							OUTSTANDING	$4.20	$0.00	$0.00
249778		02/06/2018	02/06/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$88.00		
249778		02/06/2018	03/30/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-74.80		
							OUTSTANDING	$13.20	$0.00	$0.00
Claim ID 255476										
255476		02/06/2018	02/12/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$5,304.00		
255476		02/06/2018	03/24/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-4,508.40		
							OUTSTANDING	$795.60	$0.00	$0.00
255476		02/06/2018	02/12/2018	CHARGE		STATE FARM INSURANCE	NIKHIL VERMA	$1,729.00		
255476		02/06/2018	03/24/2018	PAYMENT		STATE FARM INSURANCE	NIKHIL VERMA	$-1,469.65		
							OUTSTANDING	$259.35	$0.00	$0.00
Claim ID 255980										
255980		02/06/2018	02/12/2018	CHARGE		STATE FARM INSURANCE	KATIE GROSS	$5,304.00		
255980		02/06/2018	03/24/2018	PAYMENT		STATE FARM INSURANCE	KATIE GROSS	$-1,259.70		
							OUTSTANDING	$4,044.30	$0.00	$0.00
255980		02/06/2018	02/12/2018	CHARGE		STATE FARM INSURANCE	KATIE GROSS	$1,729.00		
255980		02/06/2018	03/24/2018	PAYMENT		STATE FARM INSURANCE	KATIE GROSS	$-410.64		
							OUTSTANDING	$1,318.36	$0.00	$0.0

APPENDIX G

REDACTED

NOTICE OF UPDATED PHYSICIAN'S LIEN

TO: Law Office of Jonathan S. Lustig
State Farm Claim #: [redacted]
Jian Ren He #: [redacted]

PLEASE TAKE NOTICE that the undersigned, a duly licensed and practicing physician in the State of Illinois, has rendered or will render services by way of treatment to **Jian Ren He** residing at [redacted] **60616** for injuries sustained on **09/12/2017.** The following named party or parties may be liable to make compensation to said injured person on account of any claims or rights of action which said injured person may have:

Name of Parties Who May Be Liable:
Law Office of Jonathan S. Lustig
State Farm Claim #: [redacted]
Jian Ren He

Address:
200 E. Randolph St. Ste. 5100 Chicago, IL. 60601
PO Box 106171 Atlanta, GA 30348
[redacted]

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the law of the State of Illinois relating to Physician's Liens, upon all claims and causes of action of said injured person for his reasonable charges for services rendered u[redacted]

PROOF OF SERVICE

STATE OF ILLINOIS
COUNTY OF COOK

Nancy Aranda (708)236-2724
Brenda Thurman(708) 236-2633
Jackie Moreno (708)236-2779
Authorized Representative on behalf of:

Dr Verma, Gross, Sweeney et al
Medical Service Provider(s) at
Midwest Orthopaedics at Rush, LLC
1611 W Harrison St
Chicago Il 60612

<u>This Physician lien represents a balance of $9,880.59. This amount is subject to change. Please contact our office at 708-236-2724 for the current balance before settlement.</u>

Nancy Aranda, Brenda Thurman & Jackie Moreno, being of legal age, deposes and says that on **March 18th** she served the foregoing Notice of Physician's Lien upon the above-mentioned person(s) by: Mailing a true copy thereof by Certified Mail to the above-named person(s) at their respective addresses shown above.

Sworn and subscribed to before me this **18th** day of **March 2019**

Seal

OFFICIAL SEAL
CAROLYN KAY BROUETTE
Notary Public - State of Illinois
My Commission Expires 7/17/2020

[redacted]
Notary Public

APPENDIX H

REDACTED

NOTICE OF PHYSICIAN'S LIEN

TO: State Farm Claim# 131429C38
Jian Ren He

PLEASE TAKE NOTICE that the undersigned, a duly licensed and practicing physician in the State of Illinois, has rendered or will render services by way of treatment to **Jian Ren He** residing at [redacted] for injuries sustained on **09/12/2017.**The following named party or parties may be liable to make compensation to said injured person on account of any claims or rights of action which said injured person may have:

Name of Parties Who May Be Liable:	Address:
State Farm Claim# [redacted]	**Po Box 106171 Atlanta, GA 30348**
Jian Ren He	[redacted]

YOU ARE HEREBY FURTHER NOTIFIED that the undersigned claims a lien, as provided under the law of the State of Illinois relating to Physician's Liens, upon all claims and causes of action of said injured person for his reasonable charges for services rendered u[redacted]

PROOF OF SERVICE

Brenda Thurman(708) 236-2633 or
Jackie Moreno (708)236-2779
Authorized Representative on behalf of:

STATE OF ILLINOIS
COUNTY OF COOK

Dr Verma,Gross, Sweeney,et al
Medical Service Provider(s) at
Midwest Orthopaedics at Rush, LLC
1611 W Harrison St
Chicago Il 60612

This Physician lien represents a balance of $7,310.59 This amount is subject to change; please contact our office at 708-236-2633 for the current balance before settlement.

Brenda Thurman or Jackie Moreno, being of legal age, deposes and says that on **September 19th** he/she served the foregoing Notice of Physician's Lien upon the above-mentioned person(s) by: Mailing a true copy thereof by Certified Mail to the above-named person(s) at their respective addresses shown above.

Sworn and subscribed to before me this **19th** day of **September 2018**

Seal

MARY J PRZYBYLOWICZ
Official Seal
Notary Public - State of Illinois
My Commission Expires Apr 9, 2021

[redacted]
Notary Public